

# 2006



***UMP Neighborhood***

Administered by the Uniform Medical Plan

## Certificate of Coverage

Self-Insured by the State of Washington  
*Effective January 1, 2006*

# Directory

## If you have questions about... Contact...

<b>Customer Service</b>	<b>1-888-380-2822 or 425-686-1218 (Seattle area)</b> <b>Monday-Friday, 8 a.m. to 6 p.m.</b>	
<b>Appeals, First Level; Correspondence, Complaints, Preauthorization, Medical Review</b>	UMP Neighborhood P.O. Box 34578 Seattle, WA 98124-1578	Toll-free: 1-888-380-2822 Local (Seattle area): 425-686-1218 Fax: 425-670-3197
<b>Benefit Information, Certificates of Coverage, I.D. Cards, Claim Forms, Claims Status</b>	UMP Neighborhood P.O. Box 34850 Seattle, WA 98124-1850	<b>www.ump.hca.wa.gov</b> Toll-free: 1-888-380-2822 Local (Seattle area): 425-686-1218
<b>Finding a Network Provider</b>	For services in: <b>Washington and Idaho border counties</b> of Bonner, Kootenai, Latah, and Nez Perce: 1-888-380-2822 or 425-686-1218 (Seattle area) or <b>www.ump.hca.wa.gov</b> <b>Other U.S. locations (Beech Street):</b> 1-800-432-1776 or <b>www.beechstreet.com</b>	
<b>Prescription Drugs</b> Member Services, Network Pharmacies, Preferred Drugs Questions, Complaints	Express Scripts, Inc. 1-866-576-3862 Available 24 hours a day, 7 days a week	<b>www.express-scripts.com</b>
<b>First-Level Appeals, Correspondence</b>	Express Scripts, Inc. Attn: Pharmacy Appeals: WA5 Mail Route BLO390 6625 West 78th Street Bloomington, MN 55439	Fax: 1-877-852-4070 Enrollee phone: 1-866-576-3862 Provider phone: 1-800-417-8164
<b>Drug Coverage Management and Preauthorization</b>	1-800-417-8164 Provider to call on enrollee's behalf	
<b>Mail-Service Pharmacy</b> <i>First prescription, order by mail:</i> <b>Note:</b> Use Web site only for refills.	Express Scripts, Inc. P.O. Box 52166 Phoenix, AZ 85072-9886	
<b>Refills:</b>	Express Scripts, Inc. 1-866-576-3862	<b>www.express-scripts.com</b>
<b>Claims from Non-Network Pharmacies</b>	Express Scripts, Inc. WA5A P.O. Box 390873 Bloomington, MN 55439-0873	
<b>Case Management</b> See pages 18-19 for more information.	1-888-759-4855	
<b>Eligibility and Enrollment</b>	PEBB Benefit Services 1-800-200-1004 or 360-412-4200 Fax: 360-923-2602 Monday-Friday, 8 a.m. to 5 p.m.	<b>www.pebb.hca.wa.gov</b>
<b>Preventive Care Guidelines</b>	<b>www.ahcpr.gov/clinic/gcpspu.htm</b> <b>www.cdc.gov/nip/publications/ACIP-list.htm</b>	
<b>Tobacco Cessation</b>	<i>Free &amp; Clear</i> 1-800-292-2336 Monday-Friday, 8 a.m. to 6 p.m.	<b>www.freeclear.com</b>
<b>Address Changes</b>	Contact your personnel, payroll, or insurance office	
<b>Washington Hotline Numbers</b>	Alcohol and Substance Abuse 1-800-562-1240 Domestic Violence 1-800-562-6025 Emergency Contraception 1-888-668-2528 Family Planning 1-800-770-4334 HIV-AIDS (national) 1-800-342-2437 Poison Control 1-800-732-6985	

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**This booklet explains benefit provisions specific to the UMP Neighborhood and is the certificate of coverage for UMP Neighborhood enrollees. (This certificate of coverage supersedes previous certificates.) If provisions in this booklet are inconsistent with any federal or state statute or rule, the language of the statute or rule will govern. This booklet was compiled by the Washington State Health Care Authority/ Uniform Medical Plan, P.O. Box 91118, Seattle, WA 98111-9218. If you have any questions about these provisions, please contact UMP Neighborhood (see the Directory).**

# Highlights

Welcome to UMP Neighborhood! UMP Neighborhood is offered by the Uniform Medical Plan (UMP), a self-insured plan designed by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA). Enrollment is offered only to residents of King, Pierce, and Snohomish counties. Retirees with Medicare coverage are not eligible for UMP Neighborhood unless at least one of their covered dependents is not covered by Medicare.

UMP Neighborhood coverage is designed to keep you and your family healthy in addition to providing benefits in case of illness or injury. As you know, your health care coverage can be one of your most important benefits. When you enroll in UMP Neighborhood, you must select a customized network of health care providers known as a “care system.” To receive the highest benefit, you will usually need to seek care through your care system. The care systems for UMP Neighborhood were chosen based on their ability to provide cost-effective care and commitment to participate in clinical quality initiatives. Services outside the care system will usually result in higher out-of-pocket expense for you. Only urgent conditions and medical emergencies are covered outside of Washington State (see exceptions for Medicare-enrolled retirees and student dependents attending school outside the service area).

Please review this booklet carefully so that you can take advantage of all this coverage has to offer. In addition, you can visit the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) to access the following:

- Online accounts, where you can look at your medical and pharmacy claims information through secure Web sites.
- Secure e-mail to submit questions to Customer Service (through your online account).
- Benefits information.
- Care system descriptions, including information on special programs and services offered.
- UMP’s preferred drug list.
- Provider network, pharmacy network, and care system directories.
- UMP Neighborhood publications and forms.
- Links to health resources and Medicare information.
- Explanations of complaints and appeals processes.
- Frequently asked questions.

## UMP Neighborhood Features

Here are a few important plan features:

- You and each family member choose a care system from which you receive most of your health care services. The care system you choose can be different from the care systems your other family members choose.
- If you need to change care systems during the plan year, 30 days’ notice is required. If the new care system you’ve chosen is accepting new patients, your change will be effective the first of the month following the 30-day notice.
- UMP Neighborhood allows you to self-refer within your care system for most routine and specialist services without needing authorization from a primary care physician. You can also self-refer to UMP Preferred Provider Organization (PPO) providers outside your care system for alternative care services from chiropractors, acupuncturists, and naturopathic physicians, as well as for women’s health care and behavioral health services. Certain restrictions apply. Refer to the specific benefit under “Covered Expenses” beginning on page 23. In addition, see “Other Health Care Services” on page 14 for specific information on those provider types you can see without a referral from your care system provider.
- Although you can see non-network providers in Washington outside of your care system (as long as they are an approved provider type), using the network providers offers several advantages:
  - Higher level of coverage.
  - No claim forms for you to fill out.
  - Your enrollee coinsurance applies to your annual medical/surgical out-of-pocket limit.
  - Preventive care, preauthorized hospice services, and tobacco cessation services through *Free & Clear* are covered at 100% of allowed charges.
  - You’re not responsible for differences between the provider’s billed charge and the UMP allowed charge.
- All care must be medically necessary (as defined on pages 75-76) to be covered.
- Enrolling in UMP Neighborhood also gives you access to network pharmacies nationwide, where you can purchase retail prescription drugs at discounted

rates—with no claim forms to worry about. You do not need to use a pharmacy affiliated with your care system. You may also order prescriptions through our mail-service pharmacy. See pages 19-22 and 32-34 for details on your prescription drug benefits.

- Only urgent conditions and medical emergencies are covered outside of Washington State (see exceptions on page 54 for Medicare-enrolled retirees, and on page 15 for student dependents attending school outside the service area).

If Medicare is your primary coverage, please refer to “UMP Neighborhood Provisions for Retirees on Medicare” on page 45. UMP Neighborhood care systems and restrictions on out-of-state services may not apply to you.

## How to Use the Plan

- Upon enrollment, you and each enrolled family member will be required to choose a care system. Once you have enrolled in a care system, you can self-refer to any provider included in that care system; however, please note that physical, occupational, speech, and massage therapy require a prescription and plan of treatment from the clinician overseeing your care.
- If you need specialized care that cannot be provided by the physicians and facilities in your chosen care system, your physician can refer you outside of your care system.
- If your care system provider refers you to a UMP PPO network provider for covered services unavailable within the care system, coverage is provided at the network benefit level. If your care system provider refers you to a provider who is not contracted with the UMP PPO network, coverage will be at the out-of-network level.
- If you use the services of a provider outside your care system (with the exception of network providers listed under “Other Health Care Services” described on page 15) without a referral from your care system provider, your out-of-pocket costs will be much higher. Non-urgent/non-emergent services outside of Washington State will not be covered at all.
- You can use licensed pharmacies throughout the U.S., but it will cost you less to use UMP network pharmacies. See page 19 for details.
- When Medicare is your primary coverage, you receive network benefits when you choose a UMP PPO network provider in Washington or the Idaho counties of Bonner, Kootenai, Latah, or Nez Perce; or a doctor who accepts Medicare assignment.

- Identify yourself as a UMP Neighborhood enrollee when you make an appointment with your care system or UMP network provider.
- Present your UMP Neighborhood I.D. card when you receive health care services or have a prescription filled. When UMP Neighborhood is the primary payer (see definition on page 78), the network provider or network pharmacy will submit the claim for you.
- Remember that some services and prescription drugs require medical review/preauthorization by UMP Neighborhood (see pages 17-18 for details). This discourages unnecessary care, saves money for you and UMP Neighborhood, and helps ensure the treatment and drugs you receive are necessary and appropriate. Although you’re responsible for obtaining medical review/preauthorization from UMP Neighborhood for these services or supplies, your care system or network provider may assist you with this process. Network pharmacies can assist you with prescription drug review, if applicable.

*If you move out of the UMP Neighborhood service area (King, Pierce, and Snohomish counties) during the plan year and choose to enroll in UMP PPO, any amounts paid or services received as a UMP Neighborhood enrollee will not count towards UMP PPO deductibles, benefit limits, or your annual out-of-pocket limit. New deductibles, benefit limits, and out-of-pocket limits will apply (see page 5), and your monthly premium will increase as of the date UMP PPO coverage begins.*

## Your Rights and Responsibilities as a UMP Neighborhood Enrollee

To ensure UMP Neighborhood offers the best possible medical care, we must work together with you and your providers as partners. To achieve this goal, you must first know your rights and responsibilities.

### As a UMP Neighborhood enrollee, you have the right to:

- Be treated with respect.
- Be informed by your providers or the UMP about all appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.

- Have information about:
  - How new technology is evaluated for inclusion as a covered benefit.
  - How providers are reimbursed by UMP Neighborhood.
  - Preauthorization and review requirements.
  - Providers you select and their qualifications.
  - UMP Neighborhood and our network of providers.
  - Your covered expenses, exclusions, and maximums/limits.
- Keep your medical records and personal information confidential.
- Obtain a second opinion regarding your provider's care recommendations.
- Make decisions in consultation with your providers about your health care.
- Make recommendations about enrollee rights and responsibilities.
- Have a translator's assistance, if required, when calling UMP Neighborhood.
- Receive:
  - All medically necessary covered services and supplies described in your *Certificate of Coverage*, subject to the maximums/limits, exclusions, prescription drug deductible, and enrollee coinsurance/copays.
  - Clear information from your provider about illness or treatment before services and supplies are provided.
  - Courteous, prompt answers from UMP.
  - Timely, proper medical care without discrimination of any kind—regardless of health status or condition, sex, ethnicity, race, marital status, or religion.
  - Written explanation from UMP regarding any request to refund an overpayment.
- Voice complaints or initiate appeals about UMP Neighborhood services, decisions, or the care you receive.
- Comply with requests for information by the date given.
- Follow your providers' instructions about your health care.
- Give your providers complete information about your health to get the best possible care.
- Keep your providers' phone numbers handy and know how to make or cancel an appointment as well as how to reach your providers after hours.
- Know how to access emergency care.
- Not engage in fraud or abuse in dealing with UMP or your providers.
- Participate with your providers in making decisions about your health care.
- Pay your copayments, coinsurance, or prescription drug deductible promptly.
- Refund promptly any overpayment made to you or for you.
- Report to UMP any outside sources of health care coverage or payment as well as any changes in your dependents or in your address.
- Show the same respect to your providers and UMP as you expect from them.
- Understand your UMP Neighborhood benefits, including what's covered, preauthorization and review requirements, and other information described in this *Certificate of Coverage*.
- Use UMP Neighborhood care system and network providers when available to help ensure quality care at the lowest cost.

### **As a UMP Neighborhood enrollee, you have the responsibility to:**

- Complete and return the annual coordination of benefits questionnaire you receive from UMP Neighborhood in a timely manner to prevent delay in claims payment.

### **Information Available to You**

We support the goal of giving you and your family the detailed information you need to make the best possible health care decisions. The following information can be found in this *Certificate of Coverage*:

- List of covered expenses (see pages 23-41).
- Benefit exclusions, reductions, and maximums/limits (see pages 42-45).
- Clear explanation of complaint and appeal procedures (see pages 49-52).
- Preventive health care benefits that are covered (see pages 34-39).
- Definition of terms (see pages 72-79).

The following information is available on the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov), or by calling UMP Neighborhood Customer Service at 1-888-380-2822.

- Accreditation information, including measures used to report health plan performance such as consumer satisfaction survey results or Health Plan Employer Data and Information Set (HEDIS) measures.
- Description and justification for provider compensation programs, including any incentives or penalties intended to encourage providers to withhold services.
- Documents and other materials referred to in PEBB open enrollment materials or this *Certificate of Coverage*.
- General reimbursement or payment arrangements between UMP Neighborhood and network providers.
- How you can be involved in decisions about benefits.
- Information on UMP Neighborhood's disease management programs.
- List of network providers, including both primary care providers and specialists.
- Notice of privacy practices (includes UMP policy for protecting the confidentiality of health information; see "Confidentiality of Your Health Information" on this page).
- Preferred drug list, including policies regarding drug coverage and how drugs are added to or removed from the list.
- Procedures to follow for consulting with providers.
- Process for preauthorization/review.
- When UMP Neighborhood may retrospectively deny coverage for preauthorized care.

You may call UMP Neighborhood Customer Service for an annual accounting of all payments made by UMP Neighborhood that have been counted against any payment limits, day limits, visit limits, or other limits on your coverage.

UMP Neighborhood does not prevent or discourage providers from informing you of the care you require, including various treatment options and whether, in the provider's view, that care is consistent with UMP Neighborhood's coverage criteria. You may, at any time, obtain

health care outside of UMP Neighborhood coverage for any reason; however, you must pay for those services and supplies. In addition, UMP Neighborhood does not prevent or discourage you from discussing the merits of different health care insurers with your provider.

## Confidentiality of Your Health Information

UMP Neighborhood follows our *Notice of Privacy Practices*, available online at [www.ump.hca.wa.gov/members/planinfo/privacypractices.shtml](http://www.ump.hca.wa.gov/members/planinfo/privacypractices.shtml), or by calling Customer Service at 1-888-380-2822. Enrollee health information will be disclosed only as described in that Notice or as required or permitted by law or court order.

## Release of Information

You may be required to give UMP Neighborhood or the Health Care Authority information necessary to determine eligibility, administer benefits, or process claims. This could include medical and other records. Coverage could be denied if you don't provide the information when requested.

# Your Cost-Sharing Requirements

**Medicare-entitled retirees: Be sure to read “If You Have Other Medical Coverage” starting on page 53.**

## Annual Prescription Drug Deductible

Your annual prescription drug deductible is \$100 per person, calculated for prescriptions filled from January 1 to December 31. For families of three or more covered persons, the maximum annual prescription drug deductible payable by all members of a family combined under one subscriber's account is \$300. You must meet your full annual prescription drug deductible even if you enroll near the end of the year.

## Coinsurance

Coinsurance is the percentage of allowed charges that UMP Neighborhood pays for medically necessary covered services; enrollee coinsurance is the percentage you're required to pay when UMP Neighborhood pays less than 100%. See the “Summary of Benefits” charts on pages 6-12 for coinsurance levels.

## Copayments

A copayment is a dollar amount you pay when receiving specific services, treatments, or supplies, such as an inpatient hospitalization in your care system facility, emergency room care, or a prescription filled through our mail-service pharmacy. See the “Summary of Benefits” charts on pages 6-12 for specific copayment requirements.

## Annual Medical/Surgical Out-of-Pocket Limit

This out-of-pocket limit refers to the maximum total amount that you may be required to pay for most enrollee coinsurance and copayments each calendar year. Once your eligible enrollee coinsurance and copayment costs reach \$1,500 per person or \$3,000 per family (all family members combined under one subscriber's account), most medical/surgical network or out-of-network (see pages 76-77 for definitions) claims for covered services are paid at 100% of allowed charges for the remainder of the calendar year.

After you have reached your annual medical/surgical out-of-pocket limit, you will still be responsible for the difference between your provider's billed charge and UMP Neighborhood's allowed charge for out-of-network services (see page 14 for the difference between out-of-network and network services).

The following costs are not counted towards your annual medical/surgical out-of-pocket limit:

- Annual prescription drug deductible.
- Benefit reductions for failure to comply with medical review/preauthorization requirements.
- Charges beyond benefit maximums, limits, and allowed charges.
- Charges for expenses not covered.
- Copayments for emergency room care.
- Enrollee coinsurance/copayments for prescriptions filled at retail and mail-order pharmacies.
- Enrollee coinsurance/copayments for services from non-network providers.

*Services provided by non-network providers are covered at 60% of allowed charges regardless of whether you have satisfied your out-of-pocket limit. In many cases, a provider's billed charge is higher than the UMP's allowed charge. Your financial responsibility when using non-network providers is the combination of your 40% coinsurance plus the difference between billed and allowed charges.*

## Maximum Plan Payment

The total UMP Neighborhood will pay for all benefits is limited to a lifetime maximum of \$2,000,000 per enrollee. Up to \$10,000 of the lifetime maximum is restored automatically each January 1 for benefits paid by UMP Neighborhood during the prior calendar year. Some services are also subject to specific calendar year or other benefit limits, as detailed in the “Summary of Benefits” starting on page 6.

# Summary of Benefits

This section summarizes your UMP Neighborhood benefits.

Please note that UMP Neighborhood has no waiting period for coverage of preexisting conditions.

UMP Neighborhood covers only medically necessary services and supplies, as defined on pages 75-76. Please refer to “Covered Expenses” as well as “Expenses Not Covered, Exclusions, and Limitations” for more details.

*The fact that a provider orders a test or prescribes a treatment does not necessarily mean that it is covered by UMP Neighborhood. Please consult this Certificate of Coverage, or call UMP Neighborhood Customer Service if you have questions about whether a service or supply is covered.*

For any UMP Neighborhood covered benefit, once you have met the cost-sharing requirements, UMP Neighborhood pays at the levels shown on the following summary charts, subject to any benefit maximums or limits indicated. The percentage paid by UMP Neighborhood refers to percentage of the allowed charge only. The remaining amount of the allowed charge is your enrollee coinsurance (defined on page 74).

Only the allowed charge is covered—the maximum payment UMP Neighborhood allows for a specific service or supply (see definition on page 72). In many cases, UMP Neighborhood’s allowed charge is less than the provider’s billed charge for the service. This means that for most non-network and out-of-network services, you will be responsible for not only the enrollee coinsurance but also the difference between the billed and allowed charges.

For an explanation of network, non-network, and out-of-network reimbursement, see “Your Medical/Surgical Provider Options” on pages 13-14.

In most circumstances, UMP Neighborhood follows Medicare coverage guidelines, payment policies, and billing requirements.

Some services also have specific limits, as shown in the summary charts.

The following sections describe your UMP Neighborhood benefits along with other details you’ll need to use your coverage effectively. If you have questions, see the Directory (inside the front cover) for contact information.

*Services received outside of Washington State that are not for treatment of urgent conditions or medical emergencies are not covered.*

*For more information on what isn’t covered and benefit limits, see “Summary of Benefits” and “Expenses Not Covered, Exclusions, and Limitations.”*

# Summary of Benefits

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
<b>Acupuncture</b> 16 treatments max/year	90%	60%	No	23, 42
<b>Ambulance</b>				23, 42
Air and ground	80%	80%	No	
<b>Biofeedback</b> (if for mental health diagnosis: See Mental Health benefits)	90%	60%	No	24, 29
<b>Blood and Blood Derivatives</b>	90%	60%	No, except stem cell harvesting for transplant purposes	24
<b>Bone, Eye, and Skin Bank Services</b>	90%	60%	No	24
<b>Cardiac and Pulmonary Rehabilitation</b>	90%	60%	Yes	18, 24
<b>Chemical Dependency Treatment</b> \$13,000 maximum plan payment per consecutive 24 calendar month period for inpatient and outpatient treatment combined (\$13,000 limit excludes detox if you haven't been admitted to a chemical dependency program when receiving those services)				24, 42, 73
• <b>Inpatient</b>	100% after \$200 copay/day; \$600 max copay/person/year	60%	No	
• <b>Outpatient</b>	90%	60%	No	
<b>Diabetes Education</b> See page 25.	90%	60%	No	25, 42, 43
<b>Diagnostic Test, Laboratory, and X-Rays</b> (outpatient)	90%	60%	Certain services	25, 44
<b>Dialysis</b>	90%	60%	No	26

(continued on next page)

\* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

\*\* Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

## Summary of Benefits, continued

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
<b>Durable Medical Equipment, Supplies, and Prostheses</b> <b>Note:</b> For a wig or hairpiece to replace hair lost due to radiation or chemotherapy, \$100 lifetime max	90%	60%	Yes, for rentals over 3 months and purchases over \$1,000	26, 43, 74
<b>Emergency Room (ER)</b> ER copay waived if admitted directly from ER; copay does not count toward the medical/surgical out-of-pocket limit.	90% after \$75* copay/visit	80% after \$75* copay/visit	No	26-27, 75
<b>Hearing Care</b> \$400 max/36 months applies to routine hearing exam, hearing aid, and rental/repair combined	90%	60%	No	27, 43
<b>Home Health Care</b>	90%	60%	Yes	18, 27, 43, 75
<b>Hospice Care</b> Six months maximum benefit				18, 27, 43, 75
<ul style="list-style-type: none"> <li>• <b>Inpatient</b> <ul style="list-style-type: none"> <li>When preauthorized</li> <li>When NOT preauthorized</li> </ul> </li> <li>• <b>Respite care</b> (\$5,000 lifetime max)</li> </ul>	100% 90% 100%	60% 60% 60%	Yes No Yes	
<b>Hospital Services</b> <ul style="list-style-type: none"> <li>• <b>Inpatient</b> <ul style="list-style-type: none"> <li>Facility services <i>May not include doctors' and other professional services</i></li> <li>Professional services <i>See page 28 for important information</i></li> </ul> </li> <li>• <b>Outpatient</b></li> </ul>	100% after \$200 copay/day; \$600 max copay/person/year 90% 90%	60% 60% 60%	No; see "Physical, Occupational, and Speech Therapy" for exceptions. No No	28, 44  28
<b>Mammograms</b> <ul style="list-style-type: none"> <li>• <b>Screening mammograms</b> (beginning at age 40, every one or two years)</li> <li>• <b>Diagnostic mammograms</b></li> </ul>	100% 90%	60% 60%	No No	25, 39 25

\* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

\*\* Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
<b>Massage Therapy</b> 16 visits/max	90%	Not applicable; <b>massage therapists must be network providers to be covered.</b>	Only for services exceeding one hour per session. Treatment plan required.	18, 28, 44
<b>Mastectomy and Related Services</b>	90%	60%	No	28
<b>Mental Health Treatment</b>				18, 29, 44, 45
• <b>Inpatient:</b> 10 days max/year	100% after \$200 copay/day; \$600 max copay/person/year	60%	No, except for partial hospitalization services	
• <b>Outpatient:</b> 20 visits max/year	90%	60%	No	
<b>Naturopathic Physician Services</b>	90%	60%	No	29, 42, 43
<b>Neurodevelopmental Therapy</b> (Ages 6 years and under)				30, 44
• <b>Inpatient:</b> 60 days max/year	100% after \$200 copay/day; \$600 max copay/person/year	60%	No	
• <b>Outpatient:</b> 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	
<b>Obstetric and Newborn Care</b>				30
• <b>Inpatient</b>				
Facility charges	100% after \$200 copay/day; \$600 max copay/person/year (Routine newborn nursery care is not subject to copay.)	60%	No	
Professional services	90%	60%	No	
• <b>Outpatient</b>	90%	60%	No	
<b>Office, Clinic, and Hospital Visits</b>	90%	60%	No	30, 42, 44

(continued on next page)

\* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

\*\* Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

## Summary of Benefits, continued

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
<b>Organ Transplants</b>				18, 31, 44
• <b>Inpatient</b>				
Facility charges	100% after \$200 copay/day; \$600 max copay/person/year	60%	Yes	
Professional services	90%	60%	Yes	
• <b>Outpatient</b>				
Donor search (bone marrow, stem cell, umbilical cord) is limited to 15 searches per transplant	90%	60%	Yes	
<b>Out-of-Network Services</b> See page 77 for definition.	Not applicable	80%	Varies by service/supply	14, 77
<b>Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)</b>	90%	60%	No	31, 45
<b>Phenylketonuria (PKU) Supplements</b>	90%	60%	No	31
<b>Physical, Occupational, and Speech Therapy</b>				18, 31-32
• <b>Inpatient:</b> 60 days max/year for all therapies combined	100% after \$200 copay/day; \$600 max copay/person/year	60%	Yes	
• <b>Outpatient:</b> 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	

\* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

\*\* Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
<b>Prescription Drugs</b> (up to a 90-day supply for most drugs)				19-22, 32-34, 42, 43, 44, 45
<ul style="list-style-type: none"> <li>• <b>Retail pharmacies*:</b> Annual prescription drug deductible applies. After you meet your annual prescription drug deductible, your cost-share limit for Tier 1 and Tier 2 drugs is: \$75 per prescription for up to 30 days' supply, \$150 per prescription for 31-60 days' supply, and \$225 per prescription for 61-90 days' supply. Limit does not apply to Tier 3 drugs and prescription drug claims submitted by the enrollee.</li> </ul>				
<b>Tier 1:</b> Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs	90% (enrollee coinsurance is 10% or cost-share limit, whichever is less)	90%	Certain drugs	
<b>Tier 2:</b> Preferred brand-name drugs	70% (enrollee coinsurance is 30% or cost-share limit, whichever is less)	70%	Certain drugs	
<b>Tier 3:</b> Nonpreferred brand-name drugs and compounded drugs	50%	50%	Certain drugs	
<ul style="list-style-type: none"> <li>• <b>Mail-service pharmacy*:</b> Annual prescription drug deductible applies. If the actual price of the medication is less than the standard copay, you pay a minimum charge of \$8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.</li> </ul>				
<b>Tier 1:</b> Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs	100% after \$10 copay/refill	See note below	Certain drugs	
<b>Tier 2:</b> Preferred brand-name drugs	100% after \$40 copay/refill	See note below	Certain drugs	
<b>Tier 3:</b> Nonpreferred brand-name drugs and compounded drugs	100% after \$100 copay/refill	See note below	Certain drugs	

**Please note:** If you purchase prescription drugs from a mail-order or Internet pharmacy other than Express Scripts and submit claims yourself, prescription drug benefits will be paid as for a non-network retail pharmacy (see pages 19-21).

(continued on next page)

\* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

\*\* Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
<b>Preventive Care</b> Only certain services are covered as preventive care. See list of covered services on pages 35-39.	100%	60%	No	34-39, 42
<b>Radiation and Chemotherapy</b>	90%	60%	No	40
<b>Second Opinions</b> • <b>When required by UMP</b> • <b>When optional</b>	100%	100%	No	18, 40
<b>Skilled Nursing Facility</b> 150 days max/year	100% after \$200 copay/day; \$600 max copay/person/year	60%	Yes	18, 40, 44, 45
<b>Spinal and Extremity Manipulations</b> 10 visits max/year	90%	60%	No	40, 44
<b>Temporomandibular Joint (TMJ) Treatment</b> (surgical)	90%	60%	Yes	18, 41
<b>Tobacco Cessation Program</b> <i>Free &amp; Clear</i> program only	100%	Not covered	No	32, 41, 45
<b>Vision Care</b> • <b>Eye exams</b> (routine) Once per calendar year • <b>Vision hardware</b> Including frames, lenses, contact lenses, and fitting fees combined	90%	60%	No	41, 44, 45
<b>Well-Baby Preventive Care Services</b> See specific services covered under "Preventive Care"	100%	60%	No	34-37, 42

\* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

\*\* Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

# How UMP Neighborhood Works

## Care Systems and UMP Neighborhood Provider Network

When you choose UMP Neighborhood, you must enroll in a customized network called a “care system,” where you will receive most of your health care services. You and each covered dependent may choose different care systems. You also may self-refer outside your care system to a UMP PPO network provider for alternative care services from chiropractors, acupuncturists, and naturopathic physicians, as well as for women’s health care and behavioral health services (see page 14 for a complete list of “Other Health Care Services”).

When you use network providers, your out-of-pocket expenses will be much lower (see “Summary of Benefits” on pages 6-12), you’ll be responsible only for your enrollee cost-sharing requirements along with expenses not covered (see the section starting on page 42), and charges that exceed benefit maximums/limits.

If you need services that aren’t available within your chosen care system, your provider can refer you outside the care system. If you are referred to a provider who is part of the larger UMP PPO network, you will receive network-level benefits. If you are referred to a provider who is not part of the UMP PPO network, you will be responsible for the provider’s charges that exceed UMP Neighborhood’s allowed charge (defined on page 72), in addition to your cost-sharing requirements and any expenses not covered (see “Out-of-Network Services” on page 14).

*If Medicare is your primary coverage (see pages 53-56) or if you are a student dependent attending school outside the service area (see page 15), care system and service area coverage restrictions may not apply to you.*

When UMP Neighborhood is the primary payer (see definition on page 78), care system or network providers and pharmacies will submit your claims and call to request any required medical review/preauthorization, saving you money on your share of the bill. If you use a non-network provider or pharmacy, you’ll be responsible for obtaining any required medical review/preauthorization, and you may have to pay for services

and submit a claim form before you receive reimbursement from UMP Neighborhood.

## Changing Care Systems

If you would like to change your care system during the year, a 30-day notice is required. Call UMP Neighborhood Customer Service at 1-888-380-2822. If the new care system you have chosen is accepting new patients, your change will be effective the first of the month following the 30-day notice.

If you obtain care from a clinic in a different care system without first changing your care system selection, services will be reimbursed at the lower non-network level.

## Your Medical/Surgical Provider Options

### Network Providers

Network providers include:

- Care system providers.
- Certain other provider types (see “Other Health Care Services” on page 14) who have contracted directly with the UMP PPO network, or are part of a network that has contracted with UMP to render services to UMP Neighborhood enrollees at a reduced rate.
- Other UMP PPO network providers, if your care system provider has notified UMP Neighborhood that you have been referred for medically necessary care not obtainable within your care system.

Network providers agree to accept UMP Neighborhood’s allowed charge as payment in full for covered services. They cannot bill you for the difference between their billed charge and UMP Neighborhood’s allowed charge. And using a network provider means that you don’t have to file claims. **Exception:** For services not covered by UMP Neighborhood, network providers can bill their usual and customary charge.

To locate a network provider, you may use the UMP Neighborhood’s online provider directory on the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov), or call UMP Neighborhood Customer Service. You may also get a printed directory from Customer Service. However, please note that you will receive the most up-to-date information by calling Customer Service, as provider status may change after the directory is printed.

## Out-of-Network Services

Out-of-network services refers to services from providers:

- Who do not have a contract with UMP and to whom you have been referred by your care system provider for covered services not available within your care system; or
- To whom you have self-referred outside your care system because of urgent conditions or medical emergencies.

UMP Neighborhood's reimbursement rate for out-of-network services is 80% of allowed charges. Your enrollee coinsurance (20%) for care from an out-of-network provider does apply to your annual medical/surgical out-of-pocket limit. Most out-of-network providers can also bill you for the difference between their billed charge and UMP Neighborhood's allowed charge (see definition on page 72).

## Non-Network Providers

Non-network providers are health care providers in Washington State who are not listed in your care system directory and to whom you self-refer (except for the UMP PPO network providers identified in "Other Health Care Services" below).

UMP Neighborhood's reimbursement rate for non-network services is 60% of allowed charges. Your enrollee coinsurance (40%) for care from a non-network provider does not apply to your annual medical/surgical out-of-pocket limit. Many non-network providers can also bill you for the difference between their billed charge and UMP Neighborhood's allowed charge. This does not apply to providers who are contracted with the UMP PPO network.

## Other Health Care Services

For certain types of providers (see list below), the large UMP PPO network is available to you no matter which UMP Neighborhood care system you are enrolled in. In some cases, care systems will also list these provider types in their directories to indicate providers who are affiliated with or are recommended by the care system. However, you receive network-level coverage when you self-refer to a UMP PPO network provider of any of the following provider types:

- Acupuncturists
- Alcohol/chemical dependency centers and substance abuse treatment facilities
- Ambulatory Surgical Centers

- Audiologists
- Behavioral Health Counselors, including Licensed Mental Health Counselors, Licensed Masters of Social Work, Licensed Marriage and Family Therapists, and Licensed ARNPs with training in psychology and counseling
- Chiropractors
- Community mental health agencies
- Durable medical equipment suppliers
- *Free & Clear* tobacco cessation program
- Free standing optometry clinics
- Hearing aid fitters and dispensers
- Home health or hospice agencies
- Home infusion providers
- Massage practitioners
- Midwives
- Naturopathic physicians
- Optometrists (if outside care system, self-refer only for routine vision services)
- Ophthalmologists (if outside care system, self-refer only for routine vision services)
- Pharmacists
- Pharmacies
- Prosthetic and orthotic suppliers
- Psychologists
- Psychiatrists
- Skilled nursing facilities
- State mental hospital
- Vision hardware vendors

To find out whether a provider is contracted with the UMP PPO network, see the UMP PPO online directory at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) or call UMP Neighborhood Customer Service at 1-888-380-2822.

*Non-network massage therapists and tobacco cessation programs other than Free & Clear are not covered.*

## Self-Referral for Women's Health Care

For covered women's health care services, UMP Neighborhood enrollees will receive network-level benefits when they self-refer to a UMP PPO provider (physician, physician assistant, midwife, or advanced registered nurse practitioner)—regardless of whether the provider is affiliated with their care system. Women's health care services include:

- Maternity care, reproductive health services, and gynecological care.
- General examinations, preventive care, and medically appropriate follow-up visits for the services previously mentioned, or other health services particular to women.
- Appropriate care for other health problems that are discovered and treated during a visit for covered women's health care services.

## Coverage for Student Dependents

Student dependents attending school outside King, Pierce, and Snohomish counties may access all covered services, routine and emergent, from approved provider types outside the service area. Benefits for care from providers outside the service area of King, Pierce, and Snohomish counties will generally be paid either at 90% of allowed charges (UMP PPO providers within Washington State and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce) or at 80% of allowed charges (all other providers, including out-of-state providers). Parents with student dependents expecting to get out-of-area care should call Customer Service at 1-888-380-2822 for more detailed instructions and information.

## Approved Provider Types

Only services performed by approved provider types are covered under UMP Neighborhood.

*"Approved" can include network, out-of-network, or non-network services. Preauthorization or other qualifications may apply.*

The list of approved provider types below includes individual medical professionals, hospitals and other facilities or organizations, pharmacies, and programs.

To bill UMP directly and receive payment in accordance with UMP Neighborhood benefits, the provider must:

- Be of a type or specialty listed in this section;

- Have a current license, registration, or certificate to deliver services in his or her location;
- Perform only services within the provider's scope of practice, as defined by the licensing agency; and
- Provide services within UMP Neighborhood's benefit limits.

Approved provider types include:

- Acupuncturists, licensed (LAc).
- Alcohol/Chemical Dependency Centers and Substance Abuse Treatment Facilities, licensed with Department of Social and Health Services (DSHS) certification (must be approved by UMP); non-PhD psychologists and mental health counselors employed by these facilities are covered only when delivering services within an approved substance abuse facility *and* the facility bills for their services.
- Ambulances, licensed ground or air service.
- Ambulatory Surgical Centers (ASC), licensed (Medicare-certified or accredited by the Joint Commission on Accreditation of Healthcare Organizations or other recognized national accreditation).
- Audiologists, certified.
- Biofeedback technicians, certified; covered only when employed by and delivering services within a hospital or other UMP-approved facility *and* the employing organization bills for their services.
- Birthing centers, licensed.
- Chiropractors, licensed (Doctors of Chiropractic [DC]).
- Community mental health agencies, licensed; non-PhD psychologists and counselors employed by these agencies are covered only when employed by and delivering services within a licensed community mental health agency *and* the agency bills for their services.
- Counselors, licensed, including Licensed Marriage and Family Therapists (LMFT), Licensed Masters of Social Work (LMSW), Licensed Mental Health Counselors (LMHC), and Licensed ARNPs with training in psychology and counseling.
- Dentists, licensed (Doctors of Dental Medicine [DMD] and Doctors of Dental Surgery or Dental Science [DDS]) (see pages 24-25 for limits on dental services covered).

- Diabetes education programs (including medical nutrition therapy), Medicare-approved or otherwise approved by UMP.
- Dieticians providing services in collaboration with an approved diabetes education program (see above).
- *Free & Clear* tobacco cessation program.
- Hearing aid fitters and dispensers, licensed.
- Home health aides, licensed (covered only when employed by and delivering services within a hospice or home health agency *and* that agency bills for their services).
- Home health or hospice agencies, licensed (Medicare-certified or accredited by the Joint Commission on Accreditation of Healthcare Organizations).
- Hospitals, licensed.
- Massage practitioners, licensed (LMP); only massage practitioners accepted into the UMP provider network are considered approved providers.
- Medical nutrition therapists (MNT), Medicare-approved or otherwise approved by UMP for the treatment of diabetes mellitus (see Diabetes education programs) or chronic renal insufficiency, end-stage renal disease when dialysis is not received, or medical conditions up to 36 months after kidney transplant. MNTs are covered only when employed by and delivering services within a hospital or other UMP-approved facility and the employing organization bills for their services.
- Midwives, licensed (LM).
- Naturopaths, licensed (Naturopathic Doctors [ND]).
- Nurses, licensed including Licensed Advanced Registered Nurse Practitioners (ARNP) and Licensed Certified Nurse Midwives (CNM) (all types must be licensed); see Practical Nurses, Registered Nurses, and Registered Nurse First Assistants.
- Occupational therapists, licensed (OT).
- Optometrists, licensed (Doctors of Optometry [OD]).
- Pharmacists, licensed and registered (RPh), or Doctors of Pharmacy (PharmD).
- Pharmacies, licensed.
- Physical therapists, registered and licensed (RPT).
- Physicians, licensed (Doctors of Medicine [MD], or Doctors of Osteopathic Medicine [DO]). Self-referral to a psychiatrist for behavioral health is allowed.
- Physician Assistants, licensed (PA) (covered only when providing services under the supervision of a clinician *and* the clinician who is supervising bills for their services).
- Podiatrists, licensed (Doctors of Podiatric Medicine [DPM]).
- Practical Nurses, licensed (LPN) (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Psychologists, licensed (PhD).
- Registered Nurse First Assistants, certified and licensed (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services; only *Certified* Registered Nurse First Assistants are covered).
- Respiratory therapists, licensed (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Skilled nursing facilities, licensed (Medicare-certified).
- Speech pathologists, licensed and certified by the American Speech, Language and Hearing Association.

*Use of an approved provider type is not required for vision hardware purchases.*

## Coverage Outside Washington State

### Services Received Outside Washington State, Inside the U.S.

Only urgent conditions and medical emergencies (see definitions on pages 79 and 75) are covered outside Washington State, unless you have Medicare as your primary coverage or are a student dependent.

If Medicare is your primary coverage, you may use any provider who accepts Medicare assignment for services covered by Medicare (including providers outside of Washington State). See “UMP Neighborhood Provisions for Enrollees on Medicare” on page 54.

For student dependents attending school outside of King, Pierce, and Snohomish counties, see “Coverage for Student Dependents” on page 15.

### Services Received Outside the U.S.

Emergency care may be covered outside of the U.S. as long as the services:

- Are for urgent conditions or medical emergencies (see definitions on pages 79 and 75 );
- Are provided by an approved provider type;
- Are medically necessary (see definition on pages 75-76);
- Are appropriate for the condition being treated;
- Are not considered to be experimental or investigational by United States standards; and
- Would otherwise be covered by UMP Neighborhood.

Services that meet the above criteria are covered at the out-of-network benefit level.

Foreign claims and any requested medical records must be translated into English with specific services, charges, drugs and dosage documented, along with the currency exchange rate.

## Emergency Care

In cases of accidental injury or medical emergency, call 911 or seek care immediately. If a UMP Neighborhood network facility or provider is not available, you should obtain services from the most conveniently available approved provider. See the “Summary of Benefits” charts for coverage details.

## Medical Review

### Preauthorizing Services

UMP Neighborhood includes a program to review and approve some medical services and supplies before, during, and after they’re received. We have a medical review team to determine the appropriate treatment setting, whether the service or supply is medically necessary, if the service or supply has been accurately billed, and whether it is considered excessive. (The fact a service or supply is prescribed or furnished by a care system provider or an approved provider type does not, by itself, make it medically necessary; see definition on pages 75-76).

This program discourages unnecessary care, saves money for you and UMP Neighborhood, and helps ensure treatment is consistent with standards of good medical practice. Remember, you and your provider always make the final decision to proceed with, postpone, or cancel any admission, treatment, supply, or procedure.

All claims for hospital admissions are subject to retrospective review for medical necessity. Medical reviewers may approve a proposed admission, deny it and suggest alternative methods, or require a second opinion from another specialist.

The following services must be preauthorized by UMP Neighborhood. Your care system provider may assist you in obtaining this preauthorization from UMP Neighborhood, but it is your responsibility. Failure to obtain preauthorization prior to service may result in denial of your claim. To ensure you receive UMP Neighborhood benefits, call 1-888-380-2822 or 425-686-1218 in the Seattle area for preauthorization before receiving these services. Preauthorization requests may be faxed directly to the Medical Review Department at 425-670-3197.

- *Certain injectable drugs* on that are not normally approved for self-administration, when obtained through a retail pharmacy or UMP’s mail-service pharmacy (these drugs are indicated on the *UMP Preferred Drug List*).
- *Durable medical equipment, supplies, and prostheses:* Preauthorization is required for rentals beyond three months or for purchases over \$1,000. UMP Neighborhood will not pay for additional costs beyond allowed charges for items preauthorized, such as more costly equipment that serves the same medical purpose (for example, an electric wheelchair instead of a manual wheelchair).

*It also may be to your benefit to request preauthorization on some frequently prescribed durable medical equipment (such as light boxes, hospital beds, and breast pumps). This helps us address potential coverage issues in advance.*

- **Home health care:** Preauthorization is required for cases in which:
  - Visits are daily;
  - Visits are expected to exceed two hours a day; or
  - Length of treatment is expected to last more than three weeks.

Reauthorization is required every two weeks unless determined otherwise by Medical Review. Call 1-888-759-4855 before starting home health services; otherwise, your claim will be denied if services are later determined not medically necessary or other home health care requirements are not met.

- **Hospice care, including respite care:** Hospice care from UMP Neighborhood network providers is covered in full for up to six months when preauthorized. Respite care has a \$5,000 lifetime maximum limit.
- **Organ transplants:** All organ transplants (including bone marrow, umbilical cord, and stem cell transplants) require preauthorization. You also must be accepted into the treating facility's transplant program and follow the program's protocol.

Other services requiring preauthorization:

- Cardiac/pulmonary rehabilitation.
- Cochlear implants.
- Genetic testing, except when associated with pregnancy or when associated with treatment decisions for a condition already diagnosed. Authorization may be granted only for testing performed by a specialist center/provider designated by UMP.
- Inpatient admissions for rehabilitation (physical, occupational, and speech therapy).
- Massage therapy in excess of one hour per treatment.
- Mental health partial hospitalization services.
- Negative Pressure Wound Therapy Pumps and related services.
- Positron Emission Tomography (PET) scans, except for diagnosis or staging of cancer.

- Skilled nursing facility admissions.
- Temporomandibular joint (TMJ) surgery.

"Summary of Benefits," "Covered Expenses," and "Expenses Not Covered, Exclusions, and Limitations" contain more information on all services and supplies that require preauthorization.

## Confirming Benefits

For services not requiring preauthorization, you may call UMP Neighborhood Customer Service to ask if those services are generally covered by UMP Neighborhood. However, until a claim for services is actually submitted to UMP, UMP is unable to provide an accurate estimate of payment.

## Medical Review During Claim Processing

When claims are processed, UMP Neighborhood will verify that treatment was medically necessary and will review provider charges. This may require the submission of medical records. UMP Neighborhood reserves the right of final determination in the amount payable for any service or supply.

## Second Opinions

UMP Neighborhood's medical reviewers may require a second opinion before approving an admission or procedure. When a second opinion is requested by UMP, it will be paid at 100%. Additionally, the monies paid by UMP for the second opinion will not be counted towards your annual out-of-pocket limit. If you don't obtain a required second opinion, your benefits may be denied. See page 40 for information on second opinions you choose to get.

## Case Management for Serious Illness

### Optional Case Management

UMP Neighborhood offers an optional case management service at no cost for medical/surgical cases involving complex treatment or high expenses. These cases may be identified during the prenotification process, when hospitals notify UMP Neighborhood if you are admitted for a diagnosis that may require case management services. Optional case management services are performed under an agreement you and UMP Neighborhood enter before the case management begins.

## Required Case Management

To promote quality health care, the UMP medical director may in some cases review medical records and determine that your use of certain services is potentially harmful, excessive, or medically inappropriate. Based on this determination, UMP Neighborhood may require you to participate in and comply with a case management plan as a condition of continued benefit payment. Case management may include designating a primary physician (MD or DO) to coordinate care, and designating a single hospital and pharmacy to provide covered services or medications. UMP Neighborhood has the right to deny payment for any services received outside of the required case management plan, except medically necessary emergency services.

You have the right to appeal the medical director's determination and the required case management plan through the process outlined under "Complaint and Appeal Procedures" starting on page 49.

## Your Prescription Drug Provider Options

*Although the prescription drug benefit differs based on whether drugs are purchased at a network or non-network pharmacy, or whether it is an enrollee-submitted claim, it does not differ based on geographic location. In addition to network and non-network retail pharmacies, you also have the choice of filling your prescriptions through our mail-service pharmacy. You may receive up to a 90-day supply of medication, as prescribed by your physician, through either a retail or our mail-service pharmacy (see exception for specialty drugs on page 22).*

## Retail Pharmacies

UMP contracts for network pharmacies through Express Scripts, Inc. to serve UMP Neighborhood enrollees. Network pharmacies are available nationwide, and have agreed to provide prescription drugs at a discounted rate when you present your UMP Neighborhood I.D. card. You do not need to use a pharmacy affiliated with your care system. Although you may use any licensed pharmacy, a UMP network pharmacy will save you time and money by collecting only your annual prescription drug deductible and

applicable enrollee coinsurance at the point of sale, and filing your claims for you. In addition, by using network pharmacies to file your prescription drug claims on your behalf, you will have the advantage of a cost-share limit on Tier 1 and Tier 2 drugs (see pages 19-21). The Tier 1 and Tier 2 cost-share limit does not apply to paper claim forms submitted by an enrollee even if the drugs were purchased at a network pharmacy.

At non-network pharmacies, you will not receive a discounted rate; the Tier 1 and Tier 2 cost-share limit does not apply; and you are required to pay the full cost of the prescription at the pharmacy, submit the claim to UMP Neighborhood, and wait for reimbursement.

*To submit claims for prescriptions purchased from non-network pharmacies (either U.S. or foreign), see page 48 under "Filing a Claim."*

Transferring to a network pharmacy is easy. Just contact the network pharmacy of your choice, tell them you are a UMP Neighborhood enrollee and would like them to transfer your prescriptions from your current pharmacy. Be ready with the name and phone number of your current pharmacy as well as the prescription numbers or drug names and dosages.

Here's how it works:

- After your annual prescription drug deductible has been met, you pay a coinsurance amount when purchasing at a network retail pharmacy, based on the drug's "tier" (see chart on page 21 for details).
- It is your responsibility to present your UMP Neighborhood I.D. card when purchasing prescription drugs at a network pharmacy so that you receive the UMP discounted price for the drug.

## Mail-Service Pharmacy

*If you have primary coverage other than UMP Neighborhood that covers prescription drugs, don't send your prescription drug orders to UMP Neighborhood's mail-service pharmacy. You should use the mail-order feature of your primary plan. After your primary plan has processed your prescription, you may submit a paper claim form to UMP Neighborhood for secondary reimbursement.*

UMP Neighborhood also offers prescription drugs through our network mail-service pharmacy. After you meet the annual prescription drug deductible, you pay a fixed dollar copayment per prescription or refill, based on the applicable drug "tier" as described in the chart on page 21. To order a prescription or refill by mail, you may visit the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov), or call Express Scripts Member Services at 1-866-576-3862.

*Prescriptions faxed to the Express Scripts mail-service pharmacy MUST be faxed from the provider's office on the provider's letterhead with the following information: patient name, UMP Neighborhood I.D. number, and date of birth. Incomplete information may delay your prescription.*

## Internet or Other Mail-Order Pharmacies

UMP contracts exclusively with Express Scripts for mail-order prescription services. All other Internet or mail-order pharmacies are considered non-network. If you purchase prescriptions through a non-network mail order pharmacy:

- You will need to pay upfront for your prescriptions.
- You will need to submit a paper claim form for reimbursement (see page 48 for instructions).
- UMP Neighborhood will calculate payment as though you filled the prescription at a non-network retail pharmacy (see page 19). There is no maximum enrollee cost-share limit for Tier 1 or Tier 2 prescriptions when using non-network pharmacies.
- If the pharmacy charges more than the UMP allowed charge, you will pay the difference.

## Your Prescription Drug Benefit Amount

*See "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" on pages 32-34 for details on both the retail and mail-service pharmacy benefits.*

The amount you pay for a prescription depends on the tier level the drug falls in (see table on page 21). Using generic and preferred drugs reduces costs both for you and for UMP. Generic drugs have the same active ingredient as their brand-name counterparts and are usually less expensive. The *UMP Preferred Drug List* (PDL) is a list of prescription drugs that have been identified as providing safe, cost-effective treatment. You may still choose nonpreferred drugs but you will generally pay more if you do.

## UMP Preferred Drug List

State legislation requires that UMP Neighborhood conform to the Washington Preferred Drug List (Washington PDL), which is based on recommendations by the Washington State Pharmacy & Therapeutics Committee (P&T Committee). This independent group of practicing health-care providers meets quarterly to help ensure that the content is medically sound and supportive of your health. The list is updated periodically as new information and drugs become available. Once these reviews are completed, the UMP PDL may change based on the P&T Committee's recommendations. The UMP PDL includes drugs from the Washington PDL and Express Scripts' National Formulary. UMP uses the Express Scripts' National Formulary for drug classes not yet reviewed by the Washington State P&T Committee.

Development and maintenance of the UMP PDL is a dynamic process. UMP retains the right to update the UMP PDL or shift medications to different tiers during the year if generic or over-the-counter alternatives become available, or if there are changes to the Washington PDL or Express Scripts' National Formulary. Please note that updates are made on a quarterly basis (January, April, July, and October) to the Washington PDL. The fact that a drug is preferred one quarter does not necessarily mean that it will be preferred through the end of the year. UMP will notify enrollees of changes made to the UMP PDL or Drug Coverage Management programs if these occur during the plan year.

## Prescription Drug Benefits Summary

After you have met your annual prescription drug deductible, your cost-share for a prescription or refill is:

Tier	Enrollee's cost using network retail pharmacy (for up to a 90-day supply per prescription or refill)	Enrollee's cost at UMP's mail-service pharmacy (for up to a 90-day supply per prescription or refill)
<b>Tier 1</b> Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs*	Lesser of 10% coinsurance or maximum enrollee cost-share limit (see below**)	\$10 copay***
<b>Tier 2</b> Preferred brand-name drugs	Lesser of 30% coinsurance or maximum enrollee cost-share limit (see below**)	\$40 copay***
<b>Tier 3</b> Nonpreferred brand-name drugs and compounded prescriptions	50% coinsurance Maximum enrollee cost-share limit does not apply	\$100 copay***

\*Certain specialty drugs are limited to a 30-day supply and may be subject to other restrictions. Brand-name specialty drugs with a generic equivalent are covered under Tier 3.

\*\* **Enrollee cost-share limit:** For up to a 30-day supply, the limit is \$75. For a 31- to 60-day supply, the limit is \$150. For a 61- to 90-day supply, the limit is \$225. The maximum enrollee cost-share limit does not apply to Tier 3 drugs or drugs purchased at a non-network pharmacy.

\*\*\* If the actual price of the medication is less than the standard copay, you pay a minimum charge of \$8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.

Enrollees who use the network mail-service pharmacy have the additional convenience of requesting refills on-line by accessing Express Scripts' Web site through the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov).

To find out which drugs are listed as preferred:

- Review the *UMP Guide to Preferred Drugs*;
- Visit the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) and link to the UMP Preferred Drug List; or
- Call Express Scripts, Inc. at 1-866-576-3862.

See "Covered Expenses" starting on page 23 and "Summary of Benefits" on pages 6-12 for more information on your prescription drug benefit.

*Although in most cases you can receive up to a 90-day supply of your prescription drug, the actual supply depends on the provider prescribing the medication. If your provider orders less than a 90-day supply, the pharmacist cannot give you more. At mail-service, if your prescription is for less than a 90-day supply, your copayment will not be prorated.*

## Limits on Drug Coverage

Some medications are covered by UMP Neighborhood only for certain uses or in certain quantities. For example, since UMP Neighborhood excludes cosmetic services and supplies, a drug will not be covered if used solely for cosmetic purposes meant to enhance physical appearance. Also, drug quantity may be limited to specific amounts over certain periods. In these cases, your doctor may need to provide more information to ensure coverage conditions are met.

UMP Neighborhood may limit drugs to specific circumstances and protocols, or restrict initial and/or refill quantities where there is:

- Use outside the scope UMP Neighborhood benefits;
- A sound clinical basis;
- Inadequate evidence of cost-effectiveness; or
- Evidence that cost-effectiveness is lacking.

Certain prescription drugs are subject to quantity limits, as indicated on the UMP Preferred Drug List. For some of these drugs, you may request an exception by having your pharmacist or prescribing provider call Express Scripts at 1-800-417-8164. This review is usually completed while your pharmacist or provider is on the phone with Express Scripts. If you are not satisfied with the review decision, you may appeal (see “Complaint and Appeal Procedures” starting on page 49).

Certain other drugs may require a coverage review process for preauthorization. To find out whether a certain drug is subject to review or quantity limits, or for specific questions on drug coverage management procedures or criteria, call Express Scripts at 1-866-576-3862, or visit the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov).

For preauthorization of injectable drugs that are not normally approved for self-administration, please call the UMP Neighborhood claims office at 1-888-380-2822.

## Limits on Specialty Drugs

Drugs labeled as “specialty” on the *UMP Preferred Drug List* are limited to a 30-day maximum supply per prescription or refill. You may get your first prescription for a specialty drug filled at a retail pharmacy, but all subsequent prescriptions must be filled through CuraScript, UMP Neighborhood’s specialty pharmacy vendor. You may contact CuraScript at 1-866-413-4135, 8 a.m. to 9 p.m. Eastern Time Monday-Friday; 9 a.m. to 1 p.m. Eastern Time Saturday. A patient care coordinator will contact you to arrange for delivery of your medication. Most specialty drugs are covered at the Tier 1 rate; however, brand-name specialty drugs with a generic equivalent are covered under Tier 3. All specialty drugs are limited to a maximum 30-day supply per prescription or refill.

## What to Do if Drug Coverage Is Denied

If a network pharmacy (including mail-service and CuraScript for specialty drugs) informs you that coverage is denied, prior authorization is required, quantities are limited, or the prescription is otherwise not covered in full, your pharmacist or prescribing provider may contact Express Scripts at 1-800-417-8164. If applicable, your pharmacist or prescribing provider may initiate the Express Scripts’ coverage review process at that time. A written determination will be sent to you and your provider within approximately two business days after Express Scripts has received information from your doctor needed for the coverage review. If Express Scripts informs your pharmacist or prescribing provider that a review is not allowed, you may appeal this decision through our appeals process (see pages 49-52).

If the medication is needed immediately, you may be eligible to receive a temporary supply during the review process. Ask your pharmacist to contact Express Scripts at 1-800-417-8164 for approval of a temporary supply.

See “Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies” on pages 32-34 and “Complaint and Appeal Procedures” starting on page 49 for additional information and procedures related to prescription drug coverage.

# Covered Expenses

*The fact a physician or other provider prescribes, orders, recommends, or approves a service or supply does not, in itself, make it medically necessary (see pages 75-76).*

UMP Neighborhood benefits are payable only for medically necessary services and supplies provided in accordance with applicable medical review/preauthorization requirements, except as described for emergency care or coordination of benefits with other health plans (see pages 53-56). Services must be received from an approved provider type (see list on pages 15-16), except as specifically noted.

In most circumstances, UMP Neighborhood follows Medicare coverage guidelines. All benefits are subject to the exclusions and limits shown in “Summary of Benefits” and “Expenses Not Covered, Exclusions, and Limitations” as well as in this section. Be sure to check “Definitions” for a description of most terms used in this *Certificate of Coverage*.

For details on the annual medical/surgical out-of-pocket limit, as well as enrollee coinsurance and other cost-sharing, see “How UMP Neighborhood Works” and “Your Cost-Sharing Requirements.”

**Please note:** Services received outside the state of Washington are covered only for urgent conditions and medical emergencies, or if you are referred by your care system provider for covered services that cannot be performed by a UMP PPO network provider. See exceptions for Medicare-enrolled retirees on page 54 and for student dependents attending school outside the service area on page 15.

As described in the “Summary of Benefits” charts and “How UMP Neighborhood Works,” your level of coverage depends on the provider you use and where you receive care.

*Except when coverage is required by law, you will be liable for the costs of any services or supplies received after your UMP Neighborhood coverage ends.*

*For more information on what isn’t covered and benefit limits, see “Summary of Benefits” and “Expenses Not Covered, Exclusions, and Limitations.”*

The list of UMP Neighborhood covered expenses follows:

## Acupuncture

This benefit covers acupuncture treatments or office visits to obtain acupuncture up to a combined total of 16 visits per calendar year. Acupuncture is covered only when used as an anesthetic or to reduce pain (not instead of surgery).

## Ambulance

*If you frequently travel outside the U.S., you may want to purchase individual insurance for air ambulance services, as UMP Neighborhood covers this transportation only to the nearest facility equipped to provide the treatment needed. The fact you or your doctor prefer that you be transported to the facility nearest your home is not a consideration.*

When other transportation is not appropriate, this benefit covers ambulance services for a life-threatening illness or injury for transport:

- From the site of the medical emergency to the nearest facility equipped to treat a life-threatening illness or injury. See definition of medical emergency on pages 75-76;
- From one facility to the nearest other facility equipped to give further treatment; or
- Home (if determined medically necessary).

Charges for regularly scheduled passenger air and rail transportation from the site of the medical emergency to the nearest facility equipped to provide the treatment are covered for the patient only—for one round trip per calendar year.

Ambulance services are reimbursed at 80% of the UMP allowed charge.

If ground ambulance services are not appropriate for transporting to the nearest facility, emergency air ambulance will be covered if the situation is a medical emergency (see definition on page 75) and if air ambulance is the only appropriate method of transportation, based solely on UMP’s determination of medical necessity.

## Biofeedback Therapy

Biofeedback therapy used to treat a physical medical condition, such as hypertension (high blood pressure), is covered at normal plan payment levels. If used for mental health treatment, biofeedback therapy is covered under the mental health payment provisions and subject to annual visit limits.

## Blood and Blood Derivatives

Blood and blood derivatives, including but not limited to synthetic factors, plasma expanders, and their administration, are covered.

## Bone, Eye, and Skin Bank Services

Biologic materials supplied by human bone banks, eye banks, and skin banks are covered.

## Cardiac and Pulmonary Rehabilitation

Cardiac and pulmonary rehabilitation that meet Medicare guidelines (not maintenance therapy) are covered when preauthorized.

## Chemical Dependency Treatment

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services, up to a maximum plan payment of \$13,000 every 24 consecutive calendar month period. Chemical dependency is defined as an illness characterized by a physiological or psychological dependency on a controlled substance or on alcohol. For purposes of this benefit, treatment and services are medically necessary if recommended in the "Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II" as published in 2001 by the American Society of Addiction Medicine. Chemical dependency does not include dependence on tobacco, caffeine, or food. Covered expenses include:

- Inpatient prescription drugs prescribed in connection with chemical dependency treatment (does not include prescriptions filled through retail or mail-order pharmacies, which are covered under "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies," starting on page 32).
- Inpatient treatment according to a prescribed provider plan at a hospital or substance abuse treatment facility, subject to approval by UMP Neighborhood's medical review program.
- Outpatient substance abuse diagnosis and treatment.

If you are not yet enrolled in a formal chemical dependency treatment program, medically necessary detoxification is covered as a medical emergency and is not included in calculating the dollar maximum under the chemical dependency treatment benefit.

## Chiropractic Physician Services

See "Spinal and Extremity Manipulation" on page 40.

## Dental Services

Most dental services are not covered as a medical benefit under UMP Neighborhood. For example, dental implants, orthodontic services, and treatment for damage to teeth or gums caused by biting, chewing, grinding, or any combination of these are not covered by UMP Neighborhood. However, they may be covered by your PEBB dental plan.

Dental services covered by UMP Neighborhood are limited to:

1. General anesthesia is covered when:
  - It is provided by an anesthesiologist in a hospital or ambulatory surgical center; and
  - The charges for the hospital or ambulatory surgical center are covered by UMP Neighborhood.
2. Specific dental procedures that are performed in a hospital or ambulatory surgical center, but only if the services are medically necessary because the enrollee:
  - Is under the age of 7 with a dental condition that cannot be safely and effectively treated in a dental office; or
  - Has a dental condition that cannot be safely and effectively treated in a dental office because of a physical or developmental disability; or
  - Has a medical condition such that doing the procedure in a dental office would place the enrollee at undue risk.
3. Repair of accidental injury to natural teeth, including evaluation of the injury and development of a treatment plan. These repairs are covered, however, only if they are based on an evaluation and treatment plan completed within 30 days of the injury. Treatment may extend beyond 30 days if your provider determines treatment should start later or continue longer.

*For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."*

4. The following oral surgery procedures, whether performed by a dentist or a medical professional (other oral surgery is not covered):
- Excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth, or restorative surgery required by the excision.
  - Incision of salivary glands or ducts.
  - Obturator maintenance for cleft palate, gum reduction for gingival hyperplasia due to Dilantin or phenytoin.
  - Jaw reconstruction due to cancer.
  - Reduction of a fracture or dislocation of the jaw or facial bones.

## Diabetes Education

This benefit covers a diabetes education program approved by Medicare or otherwise authorized by UMP Neighborhood. The benefit follows Medicare protocol and criteria and includes services for:

- Newly diagnosed diabetics.
- Diabetics whose treatment regimen is changed from diet control to oral diabetes medication, or from oral diabetes medication to insulin.
- Diabetics with inadequate glycemic control as evidenced by an HbA1c level of 8.5% or more on two consecutive HbA1c determinations three or more months apart during the year before training begins.
- Persons who are at high risk for complications from inadequate glycemic control as indicated by lack of feeling in the foot or other foot complications such as foot ulcers, deformities or amputation, preproliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes.

Diabetes education services must be prescribed by an approved provider type. To find an approved diabetes education program, visit the Web site [www.diabetes.org/education/edustate2.asp](http://www.diabetes.org/education/edustate2.asp). Services provided by dietitians in collaboration with an approved diabetes education program are covered.

## Diagnostic Tests, Laboratory, and X-Rays

This benefit covers:

- Diagnostic laboratory tests, x-rays (including diagnostic mammograms), and other imaging studies.
- Electrocardiograms (EKG, ECG).
- Electroencephalograms (EEG) and similar tests.
- Pathology exams.
- Screening and diagnostic procedures during pregnancy and related genetic counseling for prenatal diagnosis of congenital disorders.
- Studies and exams to establish a diagnosis or monitor the progress and outcome of therapy.

These tests must be appropriate to the diagnosis or symptoms reported by the ordering provider.

Colonoscopies for enrollees age 50 or over will be covered under the preventive care benefit regardless of diagnosis.

Positron Emission Tomography (PET) scans require preauthorization, except for cancer diagnosis or staging.

Genetic testing requires preauthorization (except when associated with pregnancy or when associated with treatment decisions for a condition already diagnosed). Authorization may be granted only for testing performed by a specialist center/provider designated by UMP.

Charges for Magnetic Resonance Imaging (MRI) are covered when determined medically necessary and appropriate to diagnose a specific condition.

Screening mammograms in conjunction with a covered routine physical exam (subject to U.S. Preventive Services Task Force guidelines) are covered under the preventive care benefit.

In cases of alternative diagnostic approaches with different fees, UMP Neighborhood will cover the least expensive, medically reliable diagnostic method.

Electron Beam Tomography (EBT), self-referred or prescribed by your provider, is not covered.

## Dialysis

Outpatient professional and facility services necessary for dialysis are covered when prescribed by an approved provider type to treat a covered condition.

## Durable Medical Equipment, Supplies, and Prostheses

Preauthorization of durable medical equipment for rentals more than three months or purchases over \$1,000 is required.

This benefit covers services and supplies that are prescribed by an approved provider type, are medically necessary, and are used to treat a covered condition, including:

- Artificial limbs or eyes (including implant lenses prescribed by a physician and required as a result of cataract surgery or to replace a missing portion of the eye).
- Breast pump for a medical condition of the mother or infant, such as a premature baby with difficulty sucking.
- Casts, splints, crutches, trusses, and braces.
- Contraceptive supplies that require a prescription, such as diaphragms.
- Diabetes care equipment (nondisposable) such as glucometers, sharps containers, insulin injection aids and insulin pumps, as well as accessories.
- Disposable diabetic supplies not purchased in a retail pharmacy or through our mail-service pharmacy.
- Foot care appliances for diabetics to prevent complications of diabetes.
- Initial external prosthesis and bra required by breast surgery and replacement of these items when necessitated by normal wear, a change in medical condition, or additional surgery (also see "Mastectomy and Related Services" on page 28).
- Ostomy supplies.
- Oxygen and rental equipment for its administration.
- Penile prosthesis when impotence is caused by a covered medical condition (not psychological), is a complication directly resulting from a covered surgery, or is a result of an injury to the genitalia or spinal cord and other accepted treatment has been unsuccessful.

- Rental or purchase (at UMP Neighborhood's option) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees cannot exceed full purchase price).
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of \$100.

Equipment charges in excess of the charge for less costly equipment that serves the same medical purpose are not covered. It may help you to request preauthorization for frequently prescribed durable medical equipment items such as light boxes, hospital beds, and breast pumps. Otherwise, processing of these claims is suspended pending determination of medical necessity.

Durable medical equipment is covered at the network benefit rate only if you obtain the equipment or supply from a UMP PPO durable medical equipment supplier or other network provider.

Disposable supplies to treat diabetes purchased at a retail pharmacy or through our mail-service program are covered under the "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" benefit starting on page 32. Prescription drugs used in conjunction with durable medical equipment are also covered under the "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" benefit.

## Emergency Room

*Some hospital-based physicians (such as anesthesiologists, radiologists, pathologists, emergency room doctors, etc.) who work in a network hospital or other facility may not be network providers. If a non-network provider bills separately from the hospital and his or her billed charges exceed the UMP allowed charge, you owe the provider the difference.*

This benefit is subject to a separate \$75 copay per visit in addition to your enrollee coinsurance. It covers emergency room facility charges for diagnosis and emergency treatment of a covered illness or injury. If UMP Neighborhood determines emergency care is not medically necessary or could be rendered in a nonemergency setting with equal effectiveness, no benefits will be paid for emergency room services. Charges for professional services by physicians and other providers may be billed

*For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."*

separately and are paid according to payment rules for that provider type, services provided, and network status of the provider.

The emergency room copayment is waived if there is a direct hospital inpatient admission. However, the hospital inpatient services copayment or enrollee coinsurance will apply in these cases. See the “Summary of Benefits” for coinsurance/copayment details.

## Hearing Care

This benefit is limited to \$400 per enrollee in any 36 consecutive months. It covers:

- Hearing exams and evaluations related to the purchase of a hearing aid.
- Purchase of a hearing aid (monaural or binaural) prescribed as a result of the exam/evaluation, including:
  - Ear mold(s).
  - Hearing aid instrument.
  - Initial battery, cords, and other ancillary equipment.
  - Warranty and follow-up consultation within 30 days after delivery of hearing aid.
- Rental charges up to 30 days, if you return the hearing aid before actual purchase.
- Repair of hearing aid equipment.

To expedite claim payment for this benefit, submit the bills for the hearing exam and hearing aid purchase at the same time. Treatment for diseases/disorders of the ear or auditory canal (not related to a routine hearing exam) is covered as any other condition and not subject to the hearing care benefit limit.

## Home Health Care

UMP Neighborhood preauthorization is required for home health care in which:

- Visits are daily;
- Visits are expected to exceed two hours a day; or
- Length of treatment is expected to last more than three weeks.

Reauthorization is required every two weeks unless otherwise approved by Medical Review. Please call UMP Neighborhood at 1-888-759-4855 prior to the start of home health services in these cases.

This benefit covers services provided and billed by a licensed home health agency to treat a covered illness or injury. Services must be part of a prescribed written treatment program. The provider must certify that you are homebound and that hospital or skilled nursing facility confinement would be required in the absence of home health care. Covered expenses include:

- Ancillary services such as intermittent care (less frequently than daily visits, and under two hours per visit) from home health aides and clinical social services, provided in conjunction with the skilled services of an RN, LPN, or physical, occupational, or speech therapist.
- Disposable medical supplies as well as prescription drugs provided by the home health agency.
- Home infusion therapy.
- Visits for part-time or intermittent skilled nursing care and for physical, occupational, and speech therapy.

## Hospice Care (Including Respite Care)

If preauthorized, hospice care provided by network providers is covered at 100% of allowed charges. If not preauthorized, the normal UMP Neighborhood benefit will apply.

This benefit covers hospice care for a terminally ill enrollee for up to six months. UMP Neighborhood may grant an extension if hospice care benefits have been exhausted. Services must be part of a written program of care developed by a state-licensed or Medicare-approved hospice.

The benefit includes:

- Inpatient services and supplies provided by the hospice, such as prescription drugs, medical supplies normally used for inpatients, and rental of durable medical equipment, when ordered by the attending provider.
- Respite care for a homebound hospice patient (continuous care of more than four hours a day to give family members temporary relief from caring for the patient), covered up to a \$5,000 lifetime maximum.

## Hospital Inpatient Services

This benefit covers hospital accommodation and the following inpatient services, supplies, equipment, and prescribed drugs to treat covered conditions:

- Blood and blood derivatives.
- Bone, skin, and eye bank services.
- Diagnostic tests and exams.
- General nursing care.
- Prescription drugs administered during an inpatient stay.
- Radiation and x-ray therapy.
- Surgery.
- Take-home prescription drugs dispensed and billed by the hospital upon discharge.

Inpatient physical, occupational, and speech therapy require preauthorization.

When the hospital has only private rooms, UMP Neighborhood will determine payment based on semiprivate room rates charged by other facilities in the area. Hospitals may bill you for the additional costs of certain high-cost services or devices that do not meet the medical necessity criteria of “the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.” Examples of services for which there may be additional charges include metal-on-metal or ceramic hip prostheses. A network facility may not bill you for the difference between the standard service and the enhanced service, unless you agreed in writing to these charges prior to the service being provided.

In some cases, special-care unit accommodations, such as in a cardiac, intensive care, or isolation unit, may be covered based on the facility’s special-care room rates.

*Some hospital-based physicians (such as anesthesiologists, radiologists, pathologists, emergency room doctors, etc.) who work in a network hospital or other facility may not be UMP network providers. If a provider who is not contracted with UMP bills separately from the hospital, and his or her billed charges exceed the UMP allowed charge, you owe the provider the difference. Unless it’s an emergency, take time to check the network status of any providers involved in your care before you receive services.*

## Hospital Outpatient Services

This benefit covers services for outpatient surgery, day surgery, short-stay obstetrical services (discharged within 24 hours of admission), or observation services of less than 24 hours. It also includes outpatient ancillary services such as lab, x-rays, radiation therapy, IV infusion therapy, and physical, occupational, and speech therapy.

### Massage Therapy

**To be covered by UMP Neighborhood, a massage therapist must be a network provider.**

This benefit covers massage therapy to improve or restore function lost due to:

- An acute illness or injury; or
- An exacerbation of a chronic injury.

A maximum of 16 visits is covered per calendar year. Massage therapy exceeding one hour per session must be preauthorized.

Massage therapy services are covered only when prescribed for a diagnosed condition by a qualified clinician and based on a written treatment plan.

## Mastectomy and Related Services

This benefit covers restorative surgery necessitated by previous surgery covered under UMP PPO or UMP Neighborhood as well as mastectomy necessitated by disease, illness, or injury.

An enrollee receiving benefits in connection with a mastectomy who elects breast reconstruction is covered for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Physical complications of all stages of mastectomy, including lymphedemas.

*For more information on what isn’t covered and benefit limits, see “Summary of Benefits” and “Expenses Not Covered, Exclusions, and Limitations.”*

## Mental Health Treatment

This benefit covers hospital inpatient and outpatient services as well as professional services to treat neuropsychiatric, mental, or personality disorders, including eating disorders (bulimia and anorexia nervosa). Services from mental health providers for a mental health disorder are covered under this mental health treatment benefit, regardless of the cause of the disorder (such as postpartum depression).

Inpatient mental health treatment is limited to 10 days per calendar year. Outpatient mental health treatment is limited to 20 visits per calendar year. Visits for the sole purpose of medication management do not count toward the outpatient visit limit, and are instead covered as medical services.

As an alternative to inpatient care, UMP Neighborhood covers partial hospitalization services. With preauthorization, partial hospitalization services may count toward inpatient benefit limits at a rate of two partial hospitalization days per inpatient day, until the 10-day limit on inpatient services has been met. Partial hospitalization services (see page 77) will be considered outpatient services for determining applicable enrollee coinsurance. If you reach the 10-day limit for inpatient services, or if you do not obtain preauthorization, partial hospitalization services will count toward the 20-visit limit for outpatient services.

Services of a licensed marriage and family counselor are covered only when provided to treat neuropsychiatric, mental, or personality disorders.

Biofeedback therapy is covered under this benefit when prescribed as part of an overall treatment plan for a mental health condition.

Mental health treatment must be provided or directed by one of the following:

- Licensed community mental health agency.
- Licensed advanced registered nurse practitioner (ARNP) with training in psychology and counseling.
- Licensed physician.
- Licensed psychologist.
- Licensed Master of Social Work, Licensed Mental Health Counselor, or Licensed Marriage and Family Therapist.
- Licensed state hospital.

Services from non-PhD psychologists are covered under this benefit only when they are employed by and deliver services within a licensed community mental health agency and that agency bills for the services.

Although your care system may provide behavioral health services, you may also self-refer to a UMP PPO network mental health practitioner and receive coverage at the network level.

### **Mental Health Services and Your Rights**

UMP and state law have established standards to:

- Help ensure the competence and professional conduct of mental health service providers.
- Support your right to receive treatment only after informed consent.
- Protect the privacy of your medical information.
- Help you understand which services are covered under UMP Neighborhood and the limits on your coverage.

For more information about covered mental health services, or if you have a question or concern about your mental health benefits, please contact UMP Neighborhood.

If you think any mental health benefit you have received from UMP Neighborhood may not conform to the terms of your coverage contract or your rights under the law, contact UMP at 206-521-2000.

If you have a concern about the qualifications or professional conduct of your mental health provider, call the Washington State Department of Health at 1-800-525-0127 or their customer service department in Health Professions Quality Assurance at 360-236-4902.

## Naturopathic Physician Services

This benefit covers services of a naturopathic physician. Herbs and other nonprescription drugs, lotions, vitamins, or minerals prescribed as part of naturopathic care are not covered.

*For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."*

## Neurodevelopmental Therapy for Children Ages 6 and Younger

Children ages 6 and younger are covered until their seventh birthday for neurodevelopmental therapy to assist with motor or sensory skill, such as speech therapy for developmental disorders of articulation, language therapy to correct developmental language delay, or diagnosis or treatment of learning disabilities. Benefits are payable only where significant deterioration in the child's condition would result without such services, or to restore and improve the child's functions.

Inpatient therapy is subject to the hospital inpatient copayment or enrollee coinsurance and limited to 60 days per calendar year. Outpatient care is covered up to 60 visits per calendar year for all therapies combined.

This benefit includes only the services of UMP approved provider types authorized to perform the therapy. Services must be part of a formal written treatment plan developed in consultation with the clinician diagnosing the condition and prescribing the therapy. The child is not eligible for both the "Physical, Occupational, and Speech Therapy" benefit and this benefit for the same type of services for the same condition.

## Obstetric and Newborn Care

Genetic screening tests during pregnancy, including amniocentesis, do not require preauthorization by UMP. Genetic testing or screening outside of pregnancy requires preauthorization.

This benefit covers services for pregnancy and its complications when provided and billed by a licensed physician, nurse practitioner, licensed midwife or certified nurse midwife, hospital, or birthing center. Except in geographic areas where provider access is limited, the benefit includes only services provided by providers able to perform the full scope of obstetric services (prenatal, delivery, and postnatal care). Professional services include prenatal and postnatal care, amniocentesis and related genetic counseling and testing during pregnancy, prenatal testing (in accordance with the standards set forth in WAC 246-680-020), vaginal or cesarean delivery, and care of complications resulting from pregnancy. Hospital services are covered for obstetric care subject to the inpatient hospital copayment or enrollee coinsurance. Routine newborn nursery care will be covered during hospitalization of the mother receiving maternity benefits under this plan, and will not be subject to a separate copayment. Newborn hospitalization for other

than routine newborn care is covered subject to the hospital inpatient services copayment and/or enrollee coinsurance for the first 21 days from the date of birth, if the mother is covered by this plan.

Benefits for professional and other newborn follow-up care are also provided subject to enrollee cost-sharing amounts for the first 21 days from birth if the mother is covered by this plan. For newborn services beyond 21 days, the child must meet the plan's dependent eligibility as well as enrollment requirements, and any applicable premium must be paid.

*For information on adding a new dependent to your coverage, see pages 60 or 67-68 (or call PEBB Benefit Services at 1-800-200-1004).*

Services related to voluntary and involuntary termination of pregnancy are covered. Direct complications of infertility treatments (including selective fetal reduction) are not covered.

## Office, Clinic, and Hospital Visits

This benefit covers visits involving face-to-face interaction between patient and provider for diagnosis or treatment of covered conditions.

Family planning services (including contraceptive supplies requiring a prescription or fitting, or surgical implantation/insertion of contraceptive devices such as IUDs, cervical caps, and long-acting progestational agents) are covered as well. See "Self-Referral for Women's Health Care" on page 15.

This benefit also includes visits by the surgeon, assistant surgeon, and anesthesiologist in performing:

- Cosmetic, plastic, and reconstructive surgery, including related services and supplies, if necessary to improve or restore bodily function lost due to a non-occupational accident occurring while you're covered, or a congenital anomaly (such as cleft palate or spina bifida) in a covered dependent child.
- Elective sterilization (tubal ligation and vasectomy).
- Mastectomy and related covered benefits (see page 28).
- Surgery for a covered condition.
- Restorative surgery necessitated by previous surgery covered under UMP PPO or UMP Neighborhood.

*For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."*

## Organ Transplants

Preauthorization is required for organ transplants. This benefit covers services related to organ transplants (bone marrow and stem cell are considered organs for purposes of this benefit), including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care. Donor expenses are covered as defined below. Related services such as outpatient prescription drugs, and outpatient laboratory and x-rays may be covered under other UMP Neighborhood benefits.

Organ transplants are covered only when preauthorized, performed in a plan-designated facility, and the services meet all of the following criteria:

- The service is required because of a disease, illness, or injury and is performed for the primary purpose of preventing, improving, or stabilizing the disease, illness, or injury.
- There is sufficient evidence to indicate that the service will directly improve the length or quality of the enrollee's life. Evidence is considered to be sufficient to draw conclusions if it is from published peer-reviewed medical literature (see definition on page 77), is well-controlled, directly or indirectly relates the service to the length or quality of life, and is reproducible both within and outside of research settings.
- The service's expected beneficial effects on the length or quality of life outweigh its expected harmful effects.
- The service is a cost-effective method available to address the disease, illness, or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for the enrollee that is more conservative or substantially less costly.

In addition, you must have been accepted into the treating facility's transplant program and continue to follow that program's protocol.

Costs to remove the organ from the donor and to treat complications directly resulting from the surgery are covered by the recipient's UMP Neighborhood coverage if the:

- Donor is not eligible for coverage under any other health care plan or government-funded program;
- Organ recipient is enrolled in UMP Neighborhood; and

- Organ transplant meets the above coverage criteria.

**Benefit Limitations:** Transplants are covered only if preauthorized and performed in a plan-designated facility (see definition on page 77). Coverage of direct medical costs for bone marrow, stem cell, and umbilical cord donor searches is limited to a combined total of 15 donor searches per transplant. No other benefits are provided for services related to locating an organ transplant donor.

## Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)

This benefit covers services for outpatient surgery, day surgery, services at an ambulatory surgical center (ASC), or short-stay obstetric services (discharged within 24 hours of admission). Depending on the procedure, a separate surgical suite/facility charge is not covered in some circumstances. Although network providers cannot bill you for noncovered surgical suite/facility charges, you're usually responsible for these charges if billed by a non-network or out-of-network provider.

A doctor may be a network provider, yet perform services at a non-network day surgery/ASC. Be sure to confirm whether the facility is in your UMP Neighborhood care system prior to receiving services.

## Phenylketonuria (PKU) Supplements

Phenylketonuria (PKU) supplements are covered when prescribed and used to treat PKU.

## Physical, Occupational, and Speech Therapy

Inpatient physical, occupational, and speech therapy must be preauthorized.

This benefit covers inpatient and outpatient services to improve or restore function lost due to:

- An acute illness or injury;
- An exacerbation of a chronic injury; or
- A congenital anomaly (such as cleft lip or palate) in a covered dependent child.

Inpatient rehabilitation therapy services are covered to a maximum of 60 days per calendar year subject to the hospital inpatient copayment and/or enrollee coinsurance. If UMP Neighborhood determines inpatient care is not medically necessary or could be received in an

outpatient setting with equal effectiveness, no benefits will be paid for inpatient care.

Outpatient therapy services are covered to a maximum of 60 visits per calendar year for all therapies combined.

Services must be part of a formal written treatment plan developed in consultation with the clinician who diagnosed your condition and prescribed the therapy.

UMP Neighborhood will not cover the same type of services for the same condition under both this benefit and the “Neurodevelopmental Therapy” benefit.

## Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies

This benefit covers drugs that:

- Can be legally obtained only with a written prescription;
- Do not have an over-the-counter equivalent; and
- Are approved by the Food and Drug Administration (FDA).

These include:

- Allergy antigens.
- Certain injectable prescription medications.
- Chemotherapeutic agents for treatment of malignancies.
- Contraceptive drugs.
- Fluoride supplements for prevention of dental caries in preschool children (see page 35).
- Methadone.
- Prescription prenatal vitamins (during pregnancy).

Certain nonprescription drugs and supplies are also covered including:

- All insulin and all disposable diabetic supplies such as test strips, lancets, sharps containers, and insulin syringes used in the treatment of diabetes.
- Over-the-counter prenatal vitamins (during pregnancy).
- Nicotine replacement therapy (NRT) when recommended for participants in the *Free & Clear* tobacco cessation program (see page 41). This program and covered medications are **free of charge** to enrollees.
- Prilosec OTC.

- Other over-the-counter products and prescription drugs with over-the-counter equivalents that are specifically noted in the UMP Preferred Drug List as covered under Tier 1, Tier 2, or Tier 3.

To be covered, the above-listed prescription and non-prescription drugs and supplies **must be accompanied by a written prescription** from an approved provider type.

UMP Neighborhood prescription drug benefits are payable only for medically necessary medications and supplies. Services must be received from a licensed pharmacy employing licensed registered pharmacists.

Prescriptions from both retail and mail-order pharmacies are subject to the \$100 per person annual prescription drug deductible.

The amount you pay varies based on the following three drug “tiers” (categories):

**Tier 1:** Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs (see “Coverage for Specialty Drugs” on page 34)

**Tier 2:** Preferred brand-name drugs

**Tier 3:** Nonpreferred brand-name drugs and compounded prescriptions

See “Your Prescription Drug Benefit Amount” and the “Summary of Benefits” for additional information on the tiers and specific cost-sharing requirements.

An FDA-approved drug used for off-label indications (that is, prescribed for a use other than its FDA-approved label) is covered only if recognized as effective for treatment:

- In a standard reference compendium (defined on page 79).
- In most relevant peer-reviewed medical literature (defined on page 77), if not recognized in a standard reference compendium.
- By the federal Secretary of Health and Human Services.

No benefits will be provided for any drug when the FDA has determined its use to be contraindicated.

Certain drugs may require preauthorization. In addition, UMP Neighborhood may limit medications to specific circumstances and protocols or restrict initial and/or refill quantities where there is:

- A sound clinical basis.

*For more information on what isn't covered and benefit limits, see “Summary of Benefits” and “Expenses Not Covered, Exclusions, and Limitations.”*

- Inadequate evidence of cost-effectiveness.
- Evidence of lack of cost-effectiveness.

See “Limits on Drug Coverage” on page 22 for specific details.

You may receive up to a 90-day supply of medications at either a retail pharmacy or our mail-service pharmacy unless otherwise limited by the amount authorized by your prescriber, drug coverage management, preauthorization requirements, plan exclusions or limits, or drug availability. Specialty drugs (those that require special handling or administration) are limited to a 30-day supply; see page 22 for more information on how prescriptions for specialty drugs are handled.

*Although in most cases you can receive up to a 90-day supply of your prescription drug, the actual supply also depends on the provider prescribing your medication. If your provider orders less than a 90-day supply, the pharmacist cannot give you more. At mail-service, if your prescription is for less than a 90-day supply, your copayment will not be prorated.*

See “Your Prescription Drug Provider Options” on pages 19-20 for more information on your choice of pharmacies.

UMP Neighborhood has a preferred drug list, which for many drug classes is based on the Washington Preferred Drug List (Washington PDL) used by several state programs. This list is developed using evidence-based criteria for safe, effective, and appropriate prescribing. Although your doctor may prescribe a preferred drug or any other drug he or she thinks is medically necessary for you, the amount you pay for your prescription depends on which tier it falls under (see page 21) and where you purchase it. Please note that some drugs are not covered by UMP Neighborhood even when prescribed by your provider (see pages 42-45 for exclusions affecting drugs).

UMP retains the right to update the UMP Preferred Drug List (UMP PDL) or shift medications to different tiers during the year if generic or over-the-counter alternatives become available, or if there are changes to the Washington PDL or Express Scripts’ National Formulary. Updates are made on a quarterly basis (January, April, July, and October) to the Washington PDL. The fact that a drug is preferred one quarter does **not** necessarily mean that it will be preferred through the end of the

year. UMP will notify enrollees about any changes to the UMP PDL or the Drug Coverage Management programs if these occur during the year.

In many drug classes, when your prescribing provider indicates on your prescription for a nonpreferred drug (including certain generic drugs) that substitution is allowed, your pharmacist will substitute the UMP preferred drug. This is a requirement under a state law that applies only to state-operated prescription drug programs (such as UMP Neighborhood) and prescribers who have endorsed the state’s preferred drug list. You may ask your pharmacist to dispense the nonpreferred drug, but your out-of-pocket costs may be higher (Tier 3).

## Mail-Service Pharmacy

You may order drugs by mail using our mail-service pharmacy, applying the same annual prescription drug deductible, preauthorization requirements, and limits as for retail prescription drugs. Prescriptions are usually delivered 10 to 14 business days after the Express Scripts mail-service pharmacy receives the prescription.

*Prescriptions faxed to the Express Scripts mail-service pharmacy **MUST** be faxed from the provider’s office on the provider’s letterhead with the following information: patient name, UMP Neighborhood I.D. number, and date of birth. Otherwise, your prescription may be delayed while Express Scripts confirms the prescription.*

Prescriptions mailed or orders placed in December, but not filled until January 1 or after, will be subject to the annual prescription drug deductible applicable on the date the prescription is processed. Due to increased volume at the end of the year, UMP Neighborhood cannot guarantee that prescriptions submitted to our mail-service pharmacy in December will be processed during the current benefit year.

*If there is a manufacturer shortage of a specific drug (or other shortage that our mail-service pharmacy cannot control), and the quantity available is less than the quantity you ordered, the copayment will not be prorated. The original copayment applicable for up to a 90-day supply is charged.*

*For more information on what isn’t covered and benefit limits, see “Summary of Benefits” and “Expenses Not Covered, Exclusions, and Limitations.”*

## Coverage For Specialty Drugs

Drugs labeled as “specialty” on the *UMP Preferred Drug List* are limited to a 30-day maximum supply per prescription or refill. You may get your first prescription for a specialty drug filled at a retail pharmacy, but all subsequent prescriptions must be filled through CuraScript, UMP Neighborhood’s specialty pharmacy vendor. You may contact CuraScript at 1-866-413-4135, 8 a.m. to 9 p.m. Eastern Time Monday-Friday; 9 a.m. to 1 p.m. Eastern Time Saturday. A patient care coordinator will contact you to arrange for delivery of your medication. Most specialty drugs are covered at the Tier 1 rate; however, brand-name specialty drugs with a generic equivalent are covered under Tier 3. All specialty drugs are limited to a maximum 30-day supply per prescription or refill.

*Please note that if you get a prescription medication and it turns out you cannot use it (for example, it doesn’t work for you, or you have a reaction to it), UMP Neighborhood will not refund any part of the copayment or coinsurance, and you will have to pay the full copayment or coinsurance for any substitute prescription.*

## Preventive Care

*If you receive preventive services that exceed those listed here, they will not be reimbursed under UMP Neighborhood’s preventive care benefit. Instead, when medically necessary they will be reimbursed under the specific benefit the charges apply to (such as diagnostic tests, or laboratory and x-rays). If your provider does not bill for a routine physical exam code and instead documents a diagnosis on your claim, the services are not considered preventive.*

This benefit covers the services in the tables that follow.

Benefits for well-baby care and routine physical exams for children and adults, including immunizations, were designed based on the U.S. Preventive Services Task Force guidelines, recommendations of the National Immunization Program of the Centers for Disease Control and Prevention, and recently published peer-reviewed literature on preventive care.

Services are provided on an outpatient basis specifically to monitor and maintain health and to prevent illness.

*When received through your selected care system, the specified preventive care services shown in this section are covered at 100% of allowed charges (no coinsurance or copayments).*

*For more information on what isn’t covered and benefit limits, see “Summary of Benefits” and “Expenses Not Covered, Exclusions, and Limitations.”*

## Preventive Care: Covered Services

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once in 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to UMP Neighborhood in writing.

Children: Birth-6 years	
Screening exams	
Age	Service covered
2-4 days	Preventive health visit or home health visit, if your baby was discharged early.
Within 30 days	Preventive health visit.
2 months	Preventive health visit.
4 months	Preventive health visit.
6 months	Preventive health visit. Oral fluoride supplements for preschool children older than 6 months if primary water source deficient in fluoride.
9 months	Preventive health visit with hemoglobin/hematocrit and/or lead screening if child at risk.
12 months	Preventive health visit.
15 months	Preventive health visit.
18 months	Preventive health visit.
2-6 years	Annual preventive health visit.
Children: Ages 7-18 years	
Screening exams	
Age	Service covered
8 years	Preventive health visit.
8-18 years	HIV screening of adolescents at increased risk per U.S. Preventive Services Task Force guidelines, up to two tests annually.
10 years	Preventive health visit.
11-18 years	Up to annual preventive health visit.
18 years	Females: Pap smear and screening for chlamydia and gonorrhea (earlier if sexually active).
Children: Ages 2-18 years	
Immunizations: See immunization tables on next two pages for coverage of other immunizations.	
Age	Service covered
11 years or older	Meningococcal vaccine, if not administered previously.

The graph and explanation on the following pages represent the immunization schedule for children from birth to age 18 recommended by the National Immunization Program of the Centers for Disease Control and Prevention.

# Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2005

Vaccine ▼	Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4–6 years	11–12 years	13–18 years
Hepatitis B <sup>1</sup>		HepB #1		HepB #2			HepB #3				HepB Series		
Diphtheria, Tetanus, Pertussis <sup>2</sup>			DTaP	DTaP	DTaP	DTaP		DTaP			DTaP	Td	Td
<i>Haemophilus influenzae</i> type b <sup>3</sup>			Hib	Hib	Hib	Hib							
Inactivated Poliovirus			IPV	IPV	IPV		IPV				IPV		
Measles, Mumps, Rubella <sup>4</sup>							MMR #1				MMR #2	MMR #2	
Varicella <sup>5</sup>							Varicella				Varicella		
Pneumococcal Conjugate <sup>6</sup>				PCV	PCV	PCV	PCV			PCV	PPV		
Influenza <sup>7</sup>							Influenza (Yearly)				Influenza (Yearly)		
Hepatitis A <sup>8</sup>											Hepatitis A Series		

----- Vaccines below red line are for selected populations

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2004, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible.

Indicates age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine

are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at [www.vaers.org](http://www.vaers.org) or by telephone, **800-822-7967**.

Range of recommended ages  
Preadolescent assessment

Only if mother HBsAg(–)  
Catch-up immunization



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION



The Childhood and Adolescent Immunization Schedule is approved by:  
Advisory Committee on Immunization Practices [www.cdc.gov/nip/acip](http://www.cdc.gov/nip/acip)  
American Academy of Pediatrics [www.aap.org](http://www.aap.org)  
American Academy of Family Physicians [www.aafp.org](http://www.aafp.org)

# Footnotes

## Recommended Childhood and Adolescent Immunization Schedule

UNITED STATES • 2005

**1. Hepatitis B (HepB) vaccine.** All infants should receive the first dose of HepB vaccine soon after birth and before hospital discharge; the first dose may also be administered by age 2 months if the mother is hepatitis B surface antigen (HBsAg) negative. Only monovalent HepB may be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be administered at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks.

**Infants born to HBsAg-positive mothers** should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) at separate sites within 12 hours of birth. The second dose is recommended at age 1–2 months. The final dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9–15 months.

**Infants born to mothers whose HBsAg status is unknown** should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks.

**2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

**3. Haemophilus influenzae type b (Hib) conjugate vaccine.** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be administered at age ≥12 months.

**4. Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by age 11–12 years.

**5. Varicella vaccine.** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.

**6. Pneumococcal vaccine.** The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months and for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(RR-9):1-35.

**7. Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], and diabetes), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2004;53[RR-6]:1-40). In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–23 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2004;53(RR-6):1-40. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

**8. Hepatitis A vaccine.** Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A immunization series during any visit. The 2 doses in the series should be administered at least 6 months apart. See *MMWR* 1999;48(RR-12):1-37.

## Preventive Care: Covered Services

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once in 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to UMP Neighborhood in writing.

Men: Ages 19 Years and Older	
Screening exams	
Age	Service covered
<b>19-64 years</b>	Preventive health visit every 1-3 years.
<b>19+ years</b>	Fasting blood glucose testing every 1-3 years for patients with established diagnosis of hypertension or established diagnosis of hyperlipidemia.
<b>19-21 years</b>	HIV screening of adolescents at increased risk per U.S. Preventive Services Task Force guidelines, up to two tests annually.
<b>35-65 years</b>	Blood cholesterol/lipids screening every 5 years.
<b>50+ years</b>	Fecal occult blood test for colorectal cancer at each preventive health visit.
<b>50+ years</b> (or younger if at risk)	Flexible sigmoidoscopy once every 48 months. Colonoscopy once every 10 years, but not within 48 months of screening sigmoidoscopy.
<b>50+ years</b>	PSA (Prostate Specific Antigen) once a year at physician discretion.
<b>65+ years</b>	Preventive health visit once a year.
<b>65-75 years</b>	One-time screening ultrasound for Abdominal Aortic Aneurysm, for current or prior tobacco users.
Immunizations	
Age or other indications	Service covered
<b>19+ years</b>	<b>Tetanus/Diphtheria (Td) booster</b> once every 10 years (or more frequently if injured).
<b>19+ years</b>	<b>Varicella</b> (if no history of chickenpox and not previously immunized).
<b>19+ years</b>	<b>Influenza vaccine</b> , annually.
<b>19+ years</b>	<b>Meningococcal vaccine</b> —for college students, post-splenectomy patients, or as indicated for patients with chronic illness.
<b>40 years</b>	<b>Measles/Mumps/Rubella (MMR)</b> second dose if not administered previously.
<b>65+ years</b> (or younger with chronic illness)	<b>Pneumococcal vaccine</b> —once; plus one-time revaccination five years later for patients with chronic illness or post-splenectomy patients.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

*Annual exams from OB/GYNs count as routine preventive health visits. Women may get only one routine exam under the preventive care benefit in a 12-month period. If you go to a gynecologist for your routine exam, make sure the provider knows this is your preventive care visit for the year. If you get more than one routine exam in a 12-month period, it may be paid under the medical/surgical benefit (and therefore subject to coinsurance), or denied, depending on how the visit is billed by your provider.*

## Preventive Care: Covered Services

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once in 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to UMP Neighborhood in writing.

### Women: Ages 19 and Older

#### Screening exams

Age	Service covered
<b>19-64 years</b>	Preventive health visit every 1-3 years.
<b>19+ years</b>	Fasting blood glucose testing every 1-3 years for patients with established diagnosis of hypertension or established diagnosis of hyperlipidemia.
<b>19-21 years</b>	HIV screening of adolescents at increased risk per U.S. Preventive Services Task Force guidelines, up to two tests annually.
<b>19-39 years</b>	Pap smear and pelvic exam annually or every 1-3 years as recommended by your provider (annual chlamydia and gonorrhea screening through age 24).
<b>40+ years</b>	Mammogram every 1-2 years depending on risk factors. Pap smears and pelvic exams every 1-3 years.
<b>45-65 years</b>	Blood cholesterol/lipids every 5 years; after age 65, at physician discretion based on risk factors.
<b>50+ years</b>	Fecal occult blood home test for colorectal cancer during each preventive care visit.
<b>50+ years</b> (or younger if at risk)	Flexible sigmoidoscopy once every 48 months. Colonoscopy once every 10 years, but not within 48 months of sigmoidoscopy.
<b>65+ years</b>	Preventive health visit once a year.
<b>65+ years</b>	Bone density screening using a combination of validated risk questionnaires and densitometry techniques every two years; may begin at age 60 if at risk.

#### Immunizations

Age or other indications	Service covered
<b>19+ years</b>	<b>Tetanus/Diphtheria (Td) booster</b> once every 10 years (or more frequently if injured).
<b>19+ years</b>	<b>Varicella</b> (if no history of chickenpox and not previously immunized).
<b>19+ years</b>	<b>Influenza vaccine</b> , annually.
<b>19+ years</b>	<b>Meningococcal vaccine</b> —for college students, post-splenectomy patients, or as indicated for patients with chronic illness.
<b>Childbearing age</b> , but not during pregnancy	<b>Measles/Mumps/Rubella (MMR)</b> second dose (discuss with provider).
<b>65+ years</b> (or younger with chronic illness)	<b>Pneumococcal vaccine</b> —once; plus one-time revaccination five years later for patients with chronic illness or post-splenectomy patients.

## Radiation and Chemotherapy

This benefit covers therapeutic application of radiation and chemotherapy.

## Second Opinions

This benefit covers:

- Second opinions required under UMP Neighborhood's medical review/preauthorization or case management program (failure to obtain a second opinion when required may cause denial of benefits).
- Second opinions you choose to have, without UMP Neighborhood's requirements.

Except in an emergency, a second opinion is almost always a good idea before any major procedure or treatment program. The benefit of a second opinion may be greatest if you:

- Tell your attending physician you would like a second opinion.
- Try to get your opinion from a doctor unaffiliated with the first (preferably practicing at another institution).
- Consider seeking a second opinion on surgery from a non-surgeon.
- Let the second opinion provider know that you expect to have a thorough review of records, interview, and physical exam.

*Required second opinions are covered at 100% of the allowed charge.*

## Skilled Nursing Facility

Preauthorization is required for inpatient skilled nursing facility benefits.

This benefit covers accommodations, services, and supplies to treat an accidental injury, illness, or other covered condition—when provided in and billed by a state-licensed, Medicare-certified skilled nursing facility.

You must require continued services of skilled medical or allied health professionals that cannot be provided on an outpatient basis. Benefits are limited to 150 days per calendar year, unless UMP Neighborhood approves additional coverage in place of inpatient hospitalization.

Skilled nursing facility confinement for individuals with mental health conditions or retardation, or for care that is primarily domiciliary, convalescent, or custodial in nature is not covered.

## Spinal and Extremity Manipulations

Manipulations of the spine or extremities, performed by a chiropractor, osteopathic physician, or other approved provider type, including related office visits and diagnostic tests/x-rays, are covered to a combined total of 10 visits per calendar year. (One or more of these services performed in a single encounter will count as one visit.)

Any diagnostic test, treatment, or x-ray required to diagnose or treat spinal subluxations or extremity disorders will be denied once the 10-visit limit has been reached.

Patient education or complementary and preparatory services are not separately reimbursed by UMP Neighborhood. UMP Neighborhood defines complementary and preparatory services as interventions that are used to prepare a body region for or facilitate a response to a spinal and extremity manipulation/adjustment. The application of heat or cold, or pre-manipulation exercise programs, are considered complementary and preparatory services.

## Temporomandibular Joint (TMJ) Treatment

Surgical treatment for TMJ disorders is covered when preauthorized. Medical or dental treatment for TMJ disorders is not covered.

## Tobacco Cessation Program

The benefit covers services by the *Free & Clear* tobacco cessation program only, which provides phone counseling and education materials. If nicotine replacement therapy, Zyban, or other drugs are advised by *Free & Clear* counselors, with a prescription obtained from your provider, the medications will be covered under the prescription drug benefit. These authorized prescription drugs are not subject to the annual prescription drug deductible or enrollee coinsurance/copayment.

For more details or to enroll in the program, call 1-800-292-2336.

Tobacco or smoking cessation programs other than *Free & Clear* are not covered.

## Vision Care (Routine)

This benefit covers routine eye exams, including refractions, once each calendar year.

An allowance of \$100 toward prescription eyeglass lenses, frames, contact lenses, and fitting fees is provided every two calendar years and is not subject to enrollee coinsurance.

*You can shop anywhere for your vision hardware; your maximum benefit of \$100 applies regardless of where obtained. If you go to a provider that does not bill UMP, it is easy to submit a claim for glasses or contacts; see page 46 for instructions.*

# Expenses Not Covered, Exclusions, and Limitations

UMP Neighborhood covers only the services and conditions specifically identified in this *Certificate of Coverage*. Unless a service or condition fits into one of the specific benefit definitions, it is not covered. If you have questions, call Customer Service at 1-888-380-2822.

Here are some examples of common services and conditions that are not covered. Many others are also not covered — these are examples only, not a complete list.

1. Acupuncture, except as described under “Acupuncture” on page 23.
2. Additional portion of a physical exam beyond what is covered by the preventive care benefit (starting on page 34), such as that required for employment, travel, immigration, licensing, or insurance and related reports.
3. Alcohol/drug information or referral services or enrollment in Alcoholics Anonymous or similar programs such as services provided by schools or emergency service patrol.
4. All procedures involving selection of embryo for implantation.
5. Air ambulance, if ground ambulance would serve the same purpose, or transportation by “cabulance” or other nonemergency service.
6. Charges for completing forms or copying records, except for records requested by UMP to perform retrospective utilization review.
7. Circumcision, unless determined medically necessary for a medical condition.
8. Complications directly arising from services not covered.
9. Conditions caused by or arising from acts of war.
10. Cosmetic services or supplies, including drugs and pharmaceuticals, except for:
  - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
  - Reconstructive surgery of a congenital anomaly in a covered dependent child.
  - Restoring function.
11. Court-ordered care, unless determined by UMP Neighborhood to be medically necessary and otherwise covered.
12. Custodial care; see definition on page 73.
13. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed on pages 24-25.
14. Dietary or food supplements, including:
  - Herbal supplements, dietary supplements, medicinal foods, and homeopathic drugs;
  - Infant or adult dietary formulas, except for treatment of congenital metabolic disorders detected by newborn screening such as phenylketonuria (PKU) when specialized formulas have been established as effective for treatment;
  - Minerals; and
  - Prescription or over-the-counter vitamins (except prenatal vitamins during pregnancy).
15. Drugs or medicines not prescribed by an approved provider type, or not requiring a prescription, except as listed on page 32.
16. Educational programs, except for:
  - Diabetes education services as described on page 25.
  - The *Free & Clear* tobacco cessation program described on page 41.
  - Medical nutrition therapy for:
    - Treatment of diabetes mellitus;
    - Chronic renal insufficiency;
    - End-stage renal disease when dialysis is not received; or
    - Medical conditions up to 36 months after a kidney transplant.
17. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.

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18. Equipment not primarily intended to improve a medical condition or injury, including but not limited to:
    - Air conditioners or air purifying systems.
    - Arch supports.
    - Convenience items/options.
    - Exercise equipment.
    - Sanitary supplies.
  19. Experimental or investigational services, supplies, or drugs, except for clinical trials consistent with Medicare coverage criteria.
  20. Extracorporeal Shockwave Therapy: low-energy shock waves focused on a source of pain (soft tissue).
  21. Foot care treatment for complaints such as corns and calluses, or fallen arches; and supplies for correction or treatment of such complaints, for example corrective shoes, orthotics, or related prescriptions. See “Durable Medical Equipment, Supplies, and Prostheses” on page 26 for coverage related to diabetes.
  22. Hearing care services or supplies except as provided on page 27. For example, the following are not covered:
    - A hearing aid that exceeds specifications prescribed for correction of hearing loss.
    - Charges incurred after plan coverage ends, unless the hearing aid was ordered before that date and is delivered within 45 days after UMP Neighborhood coverage ends.
    - Expenses exceeding benefit limit (see “Hearing Care” on page 27).
    - Purchase of batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase.
  23. Home health care except as provided on page 27. For example, the following are not covered:
    - 24-hour or full-time care in the home, unless preauthorized.
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned under “Home Health Care” on page 27.
    - Unless preauthorized:
      - Daily visits;
      - Visits exceeding two hours per day; or
      - Visits continuing for more than three weeks.
    - Dietary assistance.
    - Homemaker, chore worker, or housekeeping services.
    - Custodial care.
    - Nonclinical social services.
    - Psychiatric care.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services that are not medically necessary.
  24. Homeopathic drugs, including products available only by prescription and approved by the U.S. Food and Drug Administration.
  25. Hospice care except as provided on page 27. For example, the following are not covered:
    - Any services or supplies not included in the hospice care plan, not specifically mentioned under “Hospice Care” on page 27, or provided in excess of the specified limits.
    - Expenses for normal necessities of living such as food, clothing, or household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program).
    - Legal or financial counseling.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services provided while the enrollee is receiving home health care benefits.
    - Services to other than the terminally ill enrollee including bereavement, pastoral, or spiritual counseling.

26. Hospital inpatient charges such as:
  - Admissions solely for diagnostic purposes that could be performed on an outpatient basis.
  - Beds “reserved” while the patient is being treated in a special-care unit or is on leave from the hospital.
  - High-cost services and devices that do not meet the medical necessity criteria of “the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.” Examples include metal-on-metal or ceramic hip prostheses. See additional information under “Hospital Inpatient Services” on page 28.
  - Personal items (television, special diets not medically necessary to treat the covered condition, or convenience items).
  - Private room charges, unless medically necessary and preauthorized by UMP Neighborhood.
27. Immunizations, except as described under “Preventive Care” starting on page 34. Immunizations for the purpose of travel, employment, or required because of where you reside are not covered.
28. Impotence or sexual dysfunction treatment with drugs or pharmaceuticals, except during the three-month period following radical prostatectomy.
29. Infertility or sterility testing or treatment, including drugs, pharmaceuticals, artificial insemination, or any other type of testing or treatment.
30. In vitro fertilization and all related services and supplies.
31. Learning disabilities treatment after diagnosis, except as described under “Neurodevelopmental Therapy” on page 30.
32. Maintenance therapy (see definition on page 75).2
33. Manipulations of the spine or extremities, except as described under “Spinal and Extremity Manipulations” on page 40.
34. Marital, family, or other counseling or training services, except when provided to treat neuropsychiatric, mental, or personality disorders.
35. Massage therapy, unless services meet the criteria in “Massage Therapy” on page 28. Services from massage therapists who are not network providers, and services (unless preauthorized) that exceed one hour per session, are not covered.
36. Medicare-covered services or supplies delivered under a “private contract” with a provider who does not offer services through Medicare, when Medicare is the patient’s primary coverage.
37. Mental, neuropsychiatric, or personality disorder treatment, except as described under “Mental Health Treatment” on page 29.
38. Missed appointments.
39. Non-network and out-of-network provider charges, as well as prescription charges from non-network pharmacies and enrollee-submitted claims, that are in excess of the plan’s allowed charges (see page 72).
40. Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies, or any bariatric surgery (such as gastroplasty, gastric stapling, gastric banding, or intestinal bypass), regardless of co-morbidities, complications of obesity, or any other medical condition.
41. Organ donor coverage for anyone who is not a UMP Neighborhood enrollee, or for locating a donor (such as tissue typing of family members), except as described under “Organ Transplants” on page 31.
42. Organ transplants or related services in a facility that is not a “plan-designated facility” as defined on page 77, or transportation or living expenses related to organ transplants.
43. Orthoptic therapy (eye training) or vision services, except as described under “Vision Care (Routine)” on page 41.
44. Out-of-state services that are not for urgent conditions or medical emergencies (except when your care system has notified UMP of a referral, Medicare is the primary payer, or for a covered student dependent attending school out of state).
45. Over-the-counter drugs and products, except those listed on page 32 when prescribed by an approved provider type licensed to prescribe drugs.
46. Prescription drugs that have an over-the-counter equivalent product (see definition on page 77).
47. Recreation therapy.

48. Replacement of lost or stolen medications or medications confiscated or seized by Customs or other authorities.
  49. Residential mental health treatment programs or care in a residential treatment facility.
  50. Reversal of voluntary sterilization (vasectomy or tubal ligation).
  51. Services or supplies to the extent benefits are available under any automobile medical, automobile no-fault, workers' compensation, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (Benefits are considered available if they are payable under that other policy, or would be payable if you or someone else made a claim for them and complied with that insurer's claim procedures.) However, UMP Neighborhood payments will be advanced upon request if you agree to apply for benefits under the other insurance or contract and to reimburse UMP Neighborhood when settlement is received.
  52. Services delivered by types of providers not listed as approved on pages 15-16, or by providers delivering services outside of the scope of their licenses.
  53. Services of a non-PhD psychologist, except when employed by and delivering services within a community mental health agency *and* that agency bills for such services.
  54. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage;
    - Provided by a family member;
    - That are solely for comfort (except as described in "Hospice Care" on page 27); or
    - For which you are not obligated to pay.
  55. Services received outside of required case management when you are required to participate in and comply with a case management plan as a condition of continued benefit payment (see page 19 for details and exceptions).
  56. Sexual disorder, diagnosis, counseling, or treatment.
  57. Sexual reassignment surgery, services, counseling, or supplies.
  58. Skilled nursing facility services or confinement:
    - For treatment of mental health conditions or retardation.
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial (see "Custodial Care" on page 73).
  59. Surgical treatment to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
  60. Tobacco cessation services, supplies, or medications, except as described under "Tobacco Cessation Program" on page 41.
  61. Weight-loss drugs, services, or supplies.
  62. Wilderness training programs.
- If you have questions about whether a certain service or supply is covered, call UMP Neighborhood at 1-888-380-2822 or 425-686-1218 in the Seattle area.

# Filing a Claim

**If Medicare is your primary coverage, please refer to “UMP Neighborhood Provisions for Retirees on Medicare” on page 54. UMP Neighborhood care systems and restrictions on out-of-state services may not apply to you.**

## For Medical/Surgical Services

### When Do I Need To Submit a Claim?

*When UMP Neighborhood is your primary payer and*

*your provider is in the UMP network, the provider will submit claims for you. So even if you get a bill from a network provider, don't send in a claim. If you have a question about whether a claim has been submitted, you may call UMP Neighborhood Customer Service at 1-888-380-2822.*

If you receive services from a non-network or out-of-network provider, you may need to submit a claim yourself. Also, if you have other insurance and UMP Neighborhood is not your primary payer, you may need to submit a claim for secondary payment, if your provider does not.

### How Do I Submit a Claim?

To submit a claim yourself, you'll need to obtain and mail two documents:

1. The *Uniform Medical Plan Claim Form*—available on the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov), or by calling UMP Neighborhood Customer Service at 1-888-380-2822. You must fill out Sections 1, 2, 3, and 6 completely for the claim to be processed. Fill out Section 4 if the services were for a work-related illness or injury; fill out Section 5 if the patient has other insurance coverage.
2. A document from your provider that describes the services you received and the charges. This document could be a standard claim form (“CMS 1500” claim form for individual providers or a “UB-92” form for facilities), or it could be in the form of a bill or an invoice. If you submit a standard form, your claim will be paid more quickly.

If your provider uses a non-standard claim form, the following information must appear on the provider's bill for the claim to be considered for payment:

- Patient's name and UMP Neighborhood identification number.
- Description of the illness or injury.
- Date and type of service.
- Provider's name.

If you have a claim form or bill from the provider, proof of payment (such as a receipt) is not required. However, if the only documentation you have is a receipt, send it in along with your completed claim form. Please note that if UMP has to request additional information, processing of the claim may be delayed.

Section 6 on the UMP claim form asks you whether you have paid the provider. If you check “Yes,” UMP will send payment to you. If you check “No,” UMP will send payment to the provider. For hospital claims, payment is almost always sent directly to the hospital, whether it is in the UMP network or not.

Make copies of your documents. It is a good idea to keep a copy (or keep the original and send UMP a copy) of any documents.

Mail both the UMP claim form and the provider's claim document (or bill) to:

**UMP Neighborhood**  
**P.O. Box 34850**  
**Seattle, WA 98124-1850**

## What Can I Expect After Submitting a Claim?

Most claims are processed within four weeks. If you have a question about the status of a claim and haven't heard anything, we suggest waiting four weeks before calling. To inquire about a claim, call UMP Neighborhood Customer Service at 1-888-380-2822.

Delays may be due to a variety of causes, including insufficient information on the claim form, or UMP not having up-to-date information on any other insurance you or family members may have. Also, UMP may need to ask your provider for more information, which can take additional time.

When your claim has been processed, you will receive a document called an "Explanation of Benefits." This statement explains how your claim was processed, including: procedure code(s) for services provided, date of service, patient name, billed charges, UMP allowed charge, percentage paid by UMP, amount paid by UMP, amount you

need to pay, and any amount applied to your deductible. Keep your original Explanation of Benefits and always make a copy if it needs to be sent elsewhere. UMP claims are calculated based on UMP Neighborhood benefits as stated in this *Certificate of Coverage*.

## Important Information About Submitting Claims

Claims must be submitted within 12 months of the date of service. UMP Neighborhood will not pay claims submitted by you or your provider more than 12 months after the date of service.

For additional instructions for services outside of the United States, see "Services Received Outside the U.S." on page 17.

If you or a family member has other health care coverage, see "If You Have Other Medical Coverage" on pages 53-56 for information on how UMP Neighborhood coordinates benefits with other plans.

## Calculating Benefits When UMP Neighborhood Is Your Primary Coverage: Some Sample Claims

The following examples illustrate how benefits for professional services are calculated when UMP Neighborhood is the primary payer. Assume any applicable out-of-pocket limit has not been reached.

If you see a care system provider...			
Billed Charge	UMP Allowed Charge	UMP Neighborhood Pays	You Owe
\$1,000	\$900	\$810 (90% x \$900)	\$90 (\$900-\$810)
If you self-refer to a provider outside your care system who does not contract with UMP PPO...			
Billed Charge	UMP Allowed Charge	UMP Neighborhood Pays	You Owe
\$1,000	\$900	\$540 (60% x \$900)	\$460 (\$1,000-\$540)
If you see a provider who is not contracted with UMP PPO for an urgent condition or medical emergency...			
Billed Charge	UMP Allowed Charge	UMP Neighborhood Pays	You Owe
\$1,000	\$900	\$720 (80% x \$900)	\$280 (\$1,000-\$720)

## Who Gets The Money When Claims Are Paid

If you use a network provider, UMP Neighborhood sends payment directly to the provider. In most cases, you shouldn't pay a network provider until after UMP Neighborhood has processed the claim and determined your share of the bill. However, network providers may request payment at the time services are provided when the services are not covered by UMP.

When payment is sent to the provider, UMP Neighborhood sends both you and the provider an Explanation of Benefits detailing how the claim was processed.

When payment is sent to you by UMP Neighborhood, a check will be attached to your Explanation of Benefits.

## For Prescription Drugs

- If you use a UMP network retail pharmacy to fill your prescription and show your UMP Neighborhood I.D. card at the time you purchase your prescription, the pharmacy will file the claim for you. You will pay the pharmacy any coinsurance or deductible due at that time.
- If you use a non-network retail pharmacy (or do not show your I.D. card at a network pharmacy), you will have to file a *Prescription Drug Claim Form* yourself to receive reimbursement for UMP Neighborhood's share of the prescription costs.
- Also, if you get a prescription from a mail-order or Internet pharmacy other than Express Scripts mail-service pharmacy, you will need to file a *Prescription Drug Claim Form* yourself for reimbursement.

*Foreign claims for prescription drugs must be translated into English with specific services, charges, drugs and dosage documented, along with the currency exchange rate.*

For enrollee cost-sharing on claims that you submit using a *Prescription Drug Claim Form*, see page 19.

Prescription drug claims that you submit to UMP Neighborhood are subject to the same coverage rules as other prescriptions. This means that:

- If the claim you submit exceeds the quantity level limit allowed by UMP Neighborhood or the maximum days' supply, UMP Neighborhood will pay only for the amount of the drug up to the quantity level limit or maximum days' supply.

- If you submit a prescription drug claim and the prescription was ordered before it was eligible to be refilled, UMP Neighborhood will not pay for the prescription. (This is called a "refill too soon.")

*If you do not show your UMP Neighborhood I.D. card when purchasing a prescription at a UMP network retail pharmacy, you will have to pay the full cash price and submit a Prescription Drug Claim Form. In addition, the enrollee cost-share limit on Tier 1 and Tier 2 drugs does not apply to any claims that you submit via the Prescription Drug Claim Form.*

## False Claims or Statements

Neither you nor your provider (or any person acting for you or your provider) may submit a claim for services or supplies that were not in fact received, were resold to another party, or for which you are not expected to pay.

In addition, neither you nor any person acting for you may make any false or incomplete statements on any document for your UMP Neighborhood coverage.

UMP may recover any payments or overpayments made as a result of a false claim or false statement by withholding future claim payments, by suing you, or by other means.

# Complaint and Appeal Procedures

## Complaints

### What Is a Complaint?

A complaint is an oral or written expression of dissatisfaction submitted by or for an enrollee regarding:

- Denial of coverage or payment for health care services or prescription drugs;
- Issues other than denial of coverage or payment, including dissatisfaction, delays, or conflicts with UMP Neighborhood or providers; or
- Dissatisfaction with UMP Neighborhood practices or actions unrelated to health care services or prescription drugs.

*For access to secure e-mail, go to the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) to sign up for your online access account. Or you may send e-mail to UMP Neighborhood at [umpappeals@hca.wa.gov](mailto:umpappeals@hca.wa.gov). Please note that this is not secure, and private information should not be sent to this e-mail address.*

### Complaints Not Involving Prescription Drugs

If you want to make a complaint other than one relating to prescription drugs, call 1-888-380-2822 or 425-686-1218 in the Seattle area from 8 a.m. to 6 p.m. Monday through Friday (except holidays), or write UMP Neighborhood at:

**UMP Neighborhood  
Correspondence  
P.O. Box 34578  
Seattle, WA 98124-1578  
Fax: 425-670-3197**

Complaints to UMP Neighborhood regarding medical or benefit issues, providers, and availability of health care will be referred to the UMP Medical Review Department for consideration. If you have a complaint or concern about a health care provider (such as a complaint related to a provider's conduct or ability to practice medicine safely), please contact the Department of Health by e-mail at [hpqa.csc@doh.wa.gov](mailto:hpqa.csc@doh.wa.gov) or 360-236-4700, or visit its Web site (<https://fortress.wa.gov/doh/hpqa1/disciplinary/complaint.htm>) for more information.

Complaints related to nonmedical problems will be referred to the customer service or claims manager depending on the specific concern. Most complaints can be resolved at this level.

If you submit a written complaint, UMP Neighborhood will send confirmation of receipt within five business days. You will also receive notice of the action on your complaint within 30 calendar days of receiving your complaint, and usually sooner. UMP Neighborhood will notify you if additional time is needed for a response.

### Complaints Relating to Prescription Drugs

If you are dissatisfied with issues related to your prescription drug benefit such as delays, customer service, or pharmacies, call Express Scripts at 1-866-576-3862, or communicate through UMP's Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov). Most complaints can be resolved at this level. But if your complaint cannot be resolved at this level, you may initiate an appeal within 180 days from the date the action occurred. See "First-Level Appeals" on page 51.

### Prescription Drug Coverage Management

For certain drugs, UMP Neighborhood limits quantity or therapeutic uses for which a drug can be covered over a specific period. Your provider may request coverage for these medications in excess of UMP Neighborhood limits if medically necessary. If you are adversely affected by a limit on a prescription drug that is subject to coverage review (see page 22), then your pharmacist or prescribing provider may call Express Scripts at 1-800-417-8164 to initiate drug coverage review for that particular medication. In some cases, your provider must contact Express Scripts before a decision can be made. You may be eligible for a temporary supply while the coverage review is in process. However, if you choose to receive the drug outside UMP Neighborhood's conditions, you will be responsible for the full cost of any medications for which coverage is denied.

# Appeals

## What Is an Appeal?

An appeal is an oral or written request submitted by an enrollee or his or her authorized representative for UMP Neighborhood to reconsider:

- UMP Neighborhood's adverse decision regarding a complaint;
- A claim processing issue; or
- UMP Neighborhood's decision to deny, modify, reduce, or terminate payment, coverage, or authorization for health care services or prescription drugs.

*You can also appeal decisions related to eligibility. Those include decisions where an adverse benefit decision is based on your not being eligible for coverage or not having paid premiums. Those appeals are handled separately. If your appeal involves those issues, call PEBB Benefit Services at 1-800-200-1004 or write to:*

**Health Care Authority  
PEBB Appeals  
P.O. Box 42699  
Olympia, WA 98504-2699**

## General Information About Appeals

If you are appealing a decision to change, reduce, or terminate coverage for services already being provided, UMP Neighborhood is required to continue coverage for these services during your appeal. However, if the decision to change, reduce, or terminate coverage is upheld, you will be responsible for any payments made by UMP Neighborhood during that period. If you are appealing to request payment for denied claims or approval of services not yet initiated, UMP Neighborhood is not required to cover these services while the appeal is under consideration.

UMP Neighborhood will consult with a health care professional on appeals where the decision was based in whole or in part on a medical judgment. That includes decisions based on determinations that a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate. The professional consulted in such a case will be one who has appropriate training and experience in the field of medicine involved.

Appeals may be filed by mail, fax, phone, or e-mail (see pages 51-52).

You may send written comments, documents, and any other information to UMP Neighborhood when you appeal. You may also request copies of documentation UMP Neighborhood has that is relevant to your appeal, which will be provided at no cost. Our review will consider the information you submit to us, including material that was not considered in the initial benefit decision or earlier appeal. Our review will not assume the earlier decision was correct; the reviewers will be different from those involved in the earlier decision, and not their subordinates.

## Time Limits for UMP Neighborhood to Decide Appeals

The time limits below apply to both first- and second-level appeals, and are calculated from when UMP Neighborhood receives the appeal.

- The appeal decision will be made within 30 calendar days unless a shorter time limit applies as explained below. UMP Neighborhood will request written permission from you or your representative in cases where we recommend an extension to the 30-day timeline, to obtain medical records or a second opinion.
- In appeals involving a denial of a preauthorization request, the appeal decision will be made within 15 days.
- In a situation where delay could seriously jeopardize your life, health, or ability to regain maximum function, or where a physician who knows your condition tells UMP Neighborhood that delay would cause severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal, the appeal decision will be made as soon as possible but always within 72 hours (see "Expedited Appeals" below).
- If the adverse benefit decision was based on the conclusion that the service, drug, or device is experimental or investigational, the appeal decision will be made within 20 calendar days. If the appeal would otherwise have to be decided sooner than 20 days, the shorter time limit applies.

## Expedited Appeals

If your coverage is denied and your provider determines a delay in coverage would seriously jeopardize your life, health, or ability to regain maximum function, ask your

provider to request an expedited appeal. All clinically relevant information should be submitted. The provider should contact UMP Neighborhood by phone, fax, or e-mail at:

**Phone: 206-521-2000**

**Fax: 206-521-2001**

**E-mail: [umpappeals@hca.wa.gov](mailto:umpappeals@hca.wa.gov)**

*Due to privacy laws, UMP cannot share information on appeals or complaints with family members or other persons unless the patient is a minor, or UMP has received written authorization to release personal health information to the other person. If you would like someone else to handle your appeal, a Release of Information form may be downloaded from UMP's Web site, or requested from Customer Service. If you request information about claims or appeals for a spouse, domestic partner, or child over the age of 13, you may be asked to provide written authorization from the patient to receive this information before we can release it to you.*

## First-Level Appeals

First-level appeals may be initiated orally or in writing no more than 180 calendar days after you receive notice of the action leading to the appeal. Although appeals may be made by phone or in person, putting them in writing with all of the necessary information (see below for list) will speed up the process and provide for more informed decisions.

### First-Level Appeals Not Involving Prescription Drugs

For appeals not involving prescription drugs, UMP Neighborhood will send confirmation of receipt within five business days. Claim processing disputes will be reviewed by an experienced claims examiner who did not process the original claim. Appeals about covering, authorizing, or providing health care will be evaluated by a medical review nurse not involved in the initial determination to deny, reduce, modify, or terminate services or benefits. If the medical review nurse's recommendation is to uphold denial of coverage, or a decision is made not to authorize services because they have been determined to be experimental or investigational, or not medically necessary, the appeal will be further reviewed and decided by the UMP medical director or associate medical director.

It is helpful if you include the following information when requesting an appeal:

- The subscriber's full name;
- The patient's full name;
- The UMP Neighborhood I.D. number (the one starting with a "W" on your I.D. card);
- The name(s) of any providers involved in the issue you are appealing;
- The dates when services were provided;
- Your mailing address;
- Your phone number(s) (a good time to reach you by phone is useful too);
- Your e-mail address, if you have one;
- Release of Information form, if applicable; and
- Relevant medical records from your provider, if you can get them.

Send first-level appeals **not involving prescription drugs** to:

**UMP Neighborhood**

**Medical Review**

**First-Level Appeal**

**P.O. Box 34578**

**Seattle, WA 98124-1578**

**Fax: 425-670-3197**

**E-mail: Secure e-mail via your online access account, or to [umpappeals@hca.wa.gov](mailto:umpappeals@hca.wa.gov)**

### First-Level Appeals Related to Prescription Drugs

You have the right to appeal if you or your provider disagrees with how your prescription drug claim was processed. That includes claims denial, reduction, or payment issues; applications of drug coverage management guidelines; medical necessity decisions; or drugs denied because of UMP Neighborhood benefit exclusions. To appeal a coverage denial from Express Scripts, you (or your provider on your behalf) can appeal orally or in writing within 180 calendar days of the date you received your notification of denial. In cases involving denial of coverage based on coverage review guidelines or medical necessity decisions, your provider should supply clinically relevant information to Express Scripts. Therefore, it will speed up the process and provide for more informed decisions if your provider files these appeals for you.

Send first-level appeals **related to prescription drugs** to:

**Express Scripts, Inc.**  
**Attn: Pharmacy Appeals: WA5**  
**6625 West 78th Street**  
**Mail Route BLO390**  
**Bloomington, MN 55439**  
  
**Fax: 1-877-852-4070**  
**Non-Provider Phone Number: 1-866-576-3862**  
**Provider Phone Number: 1-800-417-8164**

## Second-Level Appeals

Second-level appeals must be submitted within 180 calendar days of UMP Neighborhood's decision regarding the first-level appeal. Any additional information you have to support your appeal should be submitted with your request to appeal a determination. For second-level appeals, UMP Neighborhood will send confirmation of receipt within five business days.

Send second-level appeals **not involving prescription drugs** to:

**UMP Neighborhood**  
**Second-Level Appeal**  
**P.O. Box 34578**  
**Seattle, WA 98124-1578**  
  
**Fax: 425-670-3197**  
  
**E-mail: Secure e-mail via your online access account, or to [umpappeals@hca.wa.gov](mailto:umpappeals@hca.wa.gov)**

Second-level **prescription drug appeals** should be sent to:

**UMP Neighborhood**  
**Prescription Drug Appeal**  
**P.O. Box 91118**  
**Seattle, WA 98111-9218**  
  
**Fax: 206-521-2001**  
  
**E-mail: Secure e-mail via your online access account, or to [umpappeals@hca.wa.gov](mailto:umpappeals@hca.wa.gov)**

The second-level review will be performed by the UMP Appeals Committee, consisting of the UMP executive director or designee, UMP medical director or associate medical director, and director of compliance and enforcement, or designee.

## Independent Review

You may request an external or "independent" review in two situations. If you have appealed a decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, you may request an independent review if UMP Neighborhood exceeds the timelines for response to your appeal without good cause and without reaching a decision. Also, you may request an independent review even if UMP Neighborhood has met all timelines but you are dissatisfied with the determination of your second-level appeal. To have an external review, you must ask UMP Neighborhood to send you the forms that must be completed and returned to UMP Neighborhood. These forms authorize UMP Neighborhood to release your medical information to the independent review organization. This process is explained in the letter you receive in response to your second-level appeal, or you may call the Appeals Department at 206-521-2000.

To request the forms for an independent review by mail, fax, phone, or e-mail:

**UMP Neighborhood**  
**Independent Review Process**  
**P.O. Box 91118**  
**Seattle, WA 98111-9218**  
  
**Fax: 206-521-2001**  
**Phone: 206-521-2000**  
**E-mail: [umpappeals@hca.wa.gov](mailto:umpappeals@hca.wa.gov)**

*The external review will be done by an Independent Review Organization, or IRO. An IRO is a group of medical and benefit experts certified by the Washington State Department of Health and not affiliated with UMP Neighborhood in any way. An IRO is intended to provide unbiased, independent, clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. UMP Neighborhood will pay the IRO's charges.*

Any litigation against UMP Neighborhood must be brought in the Superior Court of Thurston County, Washington.

# If You Have Other Medical Coverage

UMP Neighborhood coordinates benefits with any other group health plan covering you so that your UMP Neighborhood and other coverage combined will pay up to 100% of allowed charges (but not more than 100%).

**Note:** This may result in your receiving one or more checks for “coordination of benefits (COB) adjustments” during the year. You receive this benefit adjustment because UMP Neighborhood benefits were available but not needed for portions of claims paid by your primary plan. Those saved UMP Neighborhood benefit dollars are later used to reimburse you for cost-share expenses (such as your coinsurance or copayments) that you paid for services earlier in that calendar year.

UMP Neighborhood coordinates benefits with the following types of plans:

1. Group or blanket disability insurance policies, and health care service contractor and health maintenance organization group agreements, issued by insurers, health care service contractors, and health maintenance organizations.
2. Union trust health and welfare plans, labor organization plans, employer plans, or employee benefit organization plans.
3. Governmental programs (including, but not limited to, Medicare and Medicaid) and certain other coverage required or provided by any statute.

Benefits are not coordinated with any individual health coverage you have purchased, only with group plans.

The group insurance plan that is primary will process the claim first for all covered expenses. The primary plan will pay its normal benefit. The other plan(s) that cover you will be considered secondary and may pay less than their normal plan benefit, since total payments combined cannot exceed 100% of the allowed charges. When Medicare or another government program is one of the payers, federal law determines which plan provides benefits first. If you enroll in Medicare and are still an active employee, your Medicare coverage is secondary to UMP Neighborhood; Medicare becomes primary when you retire.

*For retirees enrolled in Medicare, UMP Neighborhood is always secondary to Medicare for services covered by Medicare.*

## Who Pays First?

For coordination with plans other than Medicare, the following rules determine which plan is the primary payer. These rules apply in order, so the first rule below that applies to your situation will determine which plan is your primary coverage (subsequent rules **do not** apply):

### For the Subscriber

- If a plan’s contract or certificate of coverage does not say that the plan coordinates benefits, it pays primary before a plan that does coordinate benefits.
- The plan that covers the person as an active employee pays before a plan that covers that person as a retiree.
- If person has more than one employer and has coverage under multiple plans, then the plan that has covered the employee the longest is primary and pays first.
- The employer plan always pays first for an active employee also covered by Medicare.

### For a Spouse or Same-Sex Domestic Partner Covered by a UMP Neighborhood Subscriber

- If the spouse or same-sex domestic partner has other group health coverage, the other group plan pays first.
- If the spouse or same-sex domestic partner is also covered by Medicare and the subscriber is an active employee, UMP Neighborhood pays first on the spouse’s or same-sex domestic partner’s claims.

### For Dependent Children Covered by a UMP Neighborhood Subscriber

- If a dependent child has coverage through his or her employment, the child’s coverage pays before the parent’s.
- Group plans will usually be primary over certain government programs in which some children may participate.

**Dependent children of married parents:**

- The plan of the parent whose birth month and day is earlier in the year pays first (for example, the plan of a parent born April 14 is primary over the plan of a parent born August 21).
- There is an exception to this “birthday rule” for newborn children. Washington law says that the mother’s health plan must cover the newborn for the first 21 days of life, so the mother’s plan pays first for all covered charges for the first 21 days of life. After that date, standard coordination rules as stated here apply to covered charges.

**Dependent children of legally separated or divorced parents:**

- Court decrees may require a non-custodial parent to provide coverage in which the standard rules for coordination of benefits apply, or may require a non-custodial parent to assume full financial responsibility for health care costs or coverage, in which case the standard rules may not apply. These cases will follow the orders of the court.
- In the absence of a specific court decree the following order of payment applies:
  1. The plan of the custodial parent.
  2. The plan of the custodial parent’s spouse, if the custodial parent has remarried.
  3. The plan of the non-custodial parent.
  4. The plan of the spouse of the non-custodial parent, if the non-custodial parent has remarried.

**Other Types of Plans**

Group plans (including UMP Neighborhood) are usually primary over certain federal programs, such as Medicaid and programs available to veterans and certain federal retirees.

If UMP Neighborhood is the primary payer, UMP Neighborhood payment will be your normal UMP Neighborhood benefit.

**UMP Neighborhood Provisions for Retirees on Medicare**

Retirees entitled to Medicare must be enrolled in Parts A and B. UMP Neighborhood is not a Medicare supplement plan, as defined by the Washington State Insurance Commissioner.

Retirees dually enrolled in Medicare and UMP Neighborhood are not restricted to care system providers to receive the network level of benefits. Also, coverage is provided for Medicare retirees who receive covered non-urgent or non-emergent services outside of Washington State.

For services also covered by Medicare, claims from physicians who accept Medicare assignment are reimbursed at the network benefit level. Within Washington State and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce, Medicare retiree claims for other services will be reimbursed at the network level if services are provided by UMP PPO network providers. If a non-network provider is chosen, services not covered by Medicare are paid at the non-network reimbursement level. However, in geographic areas within Washington where there is no access to network providers as defined by UMP, or outside of Washington State, reimbursement is at the out-of-network level.

When Medicare coverage is primary, UMP Neighborhood does not cover any services or supplies normally covered by Medicare and obtained through a “private contract” with a physician or practitioner who does not provide services through the Medicare program.

Retirees enrolled in Medicare pay lower premiums because Medicare is the primary payer for most services. UMP Neighborhood assumes the primary payer role for services and supplies not covered by Medicare, such as most outpatient prescription drugs and certain preventive care services.

*For retirees with Medicare coverage, services from physicians who accept Medicare assignment are reimbursed at the network level when services are also covered by Medicare. This applies regardless of whether the physician is in the UMP network.*

## Coordination with Medicare

Benefits are coordinated with Medicare in the same way as they are coordinated with other coverage.

In some cases, UMP Neighborhood will pay primary for retirees enrolled in Medicare when the service or supply is covered by UMP Neighborhood but not by Medicare. Medicare-enrolled UMP Neighborhood enrollees may still be required to pay coinsurance and deductible amounts when Medicare deductibles have not been met, or when a service is not covered by Medicare.

If a facility does not bill Medicare, coverage for services may not be available under UMP Neighborhood if you are a Medicare-enrolled retiree. Call UMP Neighborhood Customer Service if you have questions regarding the status of your health care facility.

Coordination of benefits is managed in the same way for retirees as for active employees. When Medicare is primary, Medicare pays first and UMP Neighborhood pays second. Here's how the reimbursement process works under UMP Neighborhood's coordination of benefits:

- Medicare pays a portion of the bill. For all outpatient services in Alaska, Arizona, Colorado, Hawaii, Iowa, Nevada, North Dakota, Oregon, South Dakota, Washington, and Wyoming, the Part B Medicare administrator sends an electronic copy of each outpatient claim to UMP Neighborhood. You do not need to send a paper claim to UMP Neighborhood for your secondary benefit for these claims. For inpatient services, and for outpatient services in other states, Medicare sends you an Explanation of Medicare Benefits (EOMB) and you must send a copy of this to UMP Neighborhood.
- UMP Neighborhood identifies the difference between the Medicare allowed amount and the Medicare payment (the "remaining amount").
- UMP Neighborhood determines what your normal benefit would have been if UMP Neighborhood had been your only insurer.
- UMP Neighborhood pays the remaining amount or the normal UMP Neighborhood benefit amount, whichever is less.

Here's an example to illustrate how this process works, assuming that your Medicare deductible has already been satisfied and you have received care in Washington from a provider who accepts Medicare assignment.

<b>Provider's charge</b>	<b>\$300</b>
<b>Medicare Benefit Calculation</b>	
Medicare allowed charge:	\$100
Medicare pays:	\$80 (80% of \$100)
Remaining amount:	\$20
<b>UMP Neighborhood Benefit Calculation</b>	
UMP Neighborhood allowed charge:	\$200
UMP Neighborhood normal benefit:	\$180 (90% of \$200)
UMP Neighborhood pays:	\$20
<b>Enrollee Owes:</b>	<b>\$0</b>

In this example, if the provider accepts Medicare assignment, you owe nothing and cannot be billed for any amount exceeding the Medicare allowed amount.

## When the Primary Payer Is Other Than Medicare

When UMP Neighborhood is secondary to another group health plan, standard coordination of benefits applies.

*If you have primary coverage other than UMP Neighborhood that covers prescription drugs, don't send your prescription drug orders to UMP's mail-service pharmacy. You should use the mail-order service of your primary plan. After your primary plan has processed your prescription, you may submit a paper claim form to UMP Neighborhood for secondary reimbursement.*

Here's how it works:

- Your primary payer pays a portion of the bill and sends you an Explanation of Benefits (EOB); you send a copy of the bill and the EOB to UMP Neighborhood.
- UMP Neighborhood reviews the primary plan benefit calculation, and the primary plan payment.
- UMP Neighborhood determines what the normal benefit would have been if UMP Neighborhood had been the only payer.
- UMP Neighborhood compares allowed charges and determines which is the highest allowed charge, except when the primary plan is Medicare in which case the Medicare allowed amount is always used.
- UMP Neighborhood pays the difference between the highest allowed charge and the primary plan's payment, up to the normal UMP Neighborhood benefit amount.

Please contact UMP Neighborhood Customer Service at 1-888-380-2822 or 425-686-1218 in the Seattle area for assistance in answering any questions about benefits when you are covered by more than one plan.

Here's an example to illustrate the process and terms above. This example assumes that the primary plan ordinarily pays 80% of allowed charges after a \$500 deductible.

<b>Provider's charge</b>	<b>\$1,200</b>
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### Primary Plan Benefit Calculation

Primary plan's allowed charge:	\$1000
Primary plan deductible:	\$500
Primary plan pays:	\$400 (80% of \$500 balance)

### UMP Neighborhood Benefit Calculation

UMP Neighborhood allowed charge:	\$900
UMP Neighborhood normal benefit:	\$810 (90% of \$900)

### Actual Payment by UMP Neighborhood

Highest allowed charge: (primary plan)	\$1000
Primary plan's payment:	\$400

<b>UMP Neighborhood pays:</b>	<b>\$600</b>
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In the example above, you owe nothing unless this is a provider who has not agreed to accept the highest allowed charge as payment in full. If a provider is not contracted with UMP or the primary plan as a network provider, you could be billed for the difference between the provider's actual billed charge and the highest of the plans' allowed charges. If Medicare is your primary plan, the provider must accept the Medicare allowed amount, or Medicare does not cover the provider and UMP Neighborhood will not cover the provider either (see "Coordination With Medicare" on page 55).

## Coordination of Benefits (COB) Questionnaire

Please call UMP Neighborhood Customer Service to notify us of changes involving other coverage. You may receive a COB questionnaire from UMP Neighborhood. This provides UMP Neighborhood with information regarding other health care coverage. Failure to complete the form and return it to UMP Neighborhood may result in delay of claims payment. Please complete and return the form quickly.

# When Another Party Is Responsible for Injury or Illness

## How UMP Neighborhood Handles Payment

If you get injured or sick because of something someone else did, or didn't do, UMP Neighborhood covers benefits as it usually does. But if you get money back from someone else, you may have to repay UMP Neighborhood for expenses we covered for you. Even if you don't choose to file a claim against the responsible party, UMP Neighborhood can do so and you must help us by giving us whatever information we need.

For example, if you are hurt in a car accident and need medical treatment, UMP Neighborhood will pay for covered services. But if it turns out that either you or the other driver has auto insurance that should be covering your medical expenses, UMP Neighborhood can legally pursue getting money back from either or both of those insurance companies. In such a case, the auto insurance company generally has the first responsibility for those costs, not UMP Neighborhood. UMP Neighborhood pays so that you don't have to wait for auto insurance companies to settle legal questions, which can take some time.

*When another party is responsible for your injury or illness, UMP Neighborhood has the right to share in the recovery of money paid on your behalf. This is called "subrogation."*

## Recovery of Expenses Initially Paid by UMP Neighborhood

If you file a lawsuit or other legal action against someone responsible for your injury or illness and get money back, UMP Neighborhood can ask for its share, up to the amount UMP Neighborhood paid on your behalf. You must give UMP Neighborhood information on any such action, including letting UMP Neighborhood know when you file a claim or lawsuit. You must also tell us about any proposed settlement with another party.

If you do file a lawsuit, you must include a claim for expenses UMP Neighborhood paid on your behalf, and allow UMP Neighborhood to participate in the lawsuit. As stated above, if you don't file to get money from the other party, UMP Neighborhood can still do so. You are required to cooperate in the process, and must not do anything to prevent UMP Neighborhood from recovering money owed to it.

UMP Neighborhood uses a company that specializes in this field to ask for information on your injury or illness and to follow up on third-party settlements. You must complete and return any requested forms to help UMP Neighborhood pursue its share of any money. If you are concerned about privacy and have a question about whether someone asking you for information on UMP Neighborhood's behalf is legitimate, please call UMP Neighborhood Customer Service at 1-888-380-2822.

# Eligibility and Enrollment for Active Employees

## Eligibility

(See “When Coverage Begins” to determine when coverage for eligible enrollees begins)

### Eligible Employees

Employees (referred to in this book as “employees,” “subscribers” or, in some cases, “enrollees”) of state government, higher education, K-12 school districts, educational service districts, and employer groups are eligible to apply for coverage by Public Employees Benefits Board (PEBB) plans in accordance with PEBB eligibility rules in Chapter 182-12 of the Washington Administrative Code (WAC). An employee is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person.

Eligibility for employees of participating employer groups may follow either PEBB rules or rules determined by collective bargaining agreement, if approved by PEBB in accordance with Chapter 182-12 WAC.

### Eligible Dependents

Eligible subscribers may enroll dependents in their PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans. For example, a dependent child who is eligible for coverage under two or more parents or stepparents who are employed by PEBB-participating employers, may be enrolled as a dependent under the coverage of one parent or stepparent, but not more than one.

The following dependents are eligible:

1. The subscriber’s lawful spouse or same-sex domestic partner (qualified through the declaration certificate issued by PEBB).
2. Dependent children through age 19. The term “children” includes the subscriber’s biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the

subscriber’s qualified same-sex domestic partner, or children specified in a court order or divorce decree. Married children who qualify as dependents of the subscriber under the Internal Revenue Code, and additional legal dependents approved by the PEBB program are included. Dependent children beyond the age of 19 are eligible under the following conditions:

- a. Students ages 20 through age 23 are eligible if they are registered students at an accredited secondary school, college, university, vocational school, or school of nursing. Dependent student coverage begins the first day of the month in which the quarter/semester for which the student is registered begins, and ends the last day of the month in which the student stops attending or in which the quarter/semester ends. To certify and recertify eligibility, the subscriber must submit a *Student Certification/Change* form to PEBB Benefit Services for review, along with proof that the dependent is a registered student. Acceptable proof may include: i) current quarter/semester registration from the institution; or ii) past year report card/transcript from the institution. Misrepresentation or failure to notify the PEBB program of changes in status resulting in loss of eligibility, including changes in student status, may result in the subscriber being responsible for payment of services received. Dependent student coverage continues year-round for those who attend three of the four school quarters or two semesters, and for three full calendar months following graduation as long as the subscriber is covered at the same time, the dependent has not reached age 24, and the dependent meets all other eligibility requirements.

*Don’t forget! Notify PEBB Benefit Services at 1-800-200-1004 as soon as possible of changes in student status. Such changes may result in your being required to pay for services received.*

- b. Dependent children of any age are eligible if they are incapable of self-support and are individuals with disabilities, developmental disabilities, mental illness, or mental retardation, provided that their condition occurs prior to age 20, or during the time they met the criteria for student coverage under PEBB rules. The subscriber must complete an application with proof that such disability occurred either (a) before the dependent became 20 years old or (b) during the time the dependent met the criteria for student coverage as described above. The subscriber must submit the application to PEBB Benefit Services for approval by UMP. The PEBB program will, on behalf of UMP, request recertification of disability as frequently as necessary to verify the ongoing eligibility status of the dependent during the first two-year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.
3. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as (a) the parent maintains continuous coverage in a PEBB-sponsored medical plan, (b) the parent continues to qualify under the Internal Revenue Code as a dependent of an eligible subscriber, (c) the subscriber who claimed the parent as a dependent continues enrollment in a PEBB plan, and (d) the parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible subscriber; however, dependent parents may not add additional family members to their coverage.
4. Dependents of an active employee who were previously covered under a K-12 or employer group medical plan, and who are not otherwise eligible for PEBB coverage, may continue coverage under a PEBB plan for up to 36 consecutive months. To be eligible for this continuation, the PEBB plan must be immediately replacing a K-12 or employer group medical plan with no lapse in coverage.

Verification of the dependency status of anyone enrolled under PEBB coverage may be requested at any time by the PEBB program or UMP.

## Medicare Entitlement

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Office to inquire about the advantages of immediate or deferred Medicare enrollment.

For employees and their spouses or qualified same-sex domestic partners age 65 and older, the PEBB-sponsored medical plan will provide primary coverage, and Medicare coverage will be secondary. However, active employees 65 and older may choose to reject PEBB-sponsored medical coverage and choose Medicare as their primary insurer. If an employee does so, the employee will not be allowed to re-enroll in a PEBB medical plan offered to active employees. However, the employee will remain enrolled in PEBB-sponsored dental, life, and long-term disability coverage.

In most situations, employees and their spouses or qualified same-sex domestic partners can elect to defer Medicare Part B enrollment without penalty, up to the date the employee terminates or retires. Upon retirement, Medicare will become the primary insurer and the PEBB-sponsored medical plan becomes secondary.

Please contact PEBB Benefit Services for information about retiree eligibility and benefit information.

*Retirees and/or permanently disabled employees and their eligible dependents must enroll in Medicare Parts A and B if entitled.*

## Enrollment

**(See "When Coverage Begins" to determine when coverage for eligible enrollees begins.)**

Employees and their eligible dependents may enroll in this plan within 31 days of the date the employee first becomes eligible to apply for PEBB coverage as described in the "Eligibility" section. Enrollment forms are furnished by the employee's payroll, personnel, or insurance office and should be returned to that office within 31 days of the date of eligibility.

Eligible dependents who are not enrolled when they are initially eligible may be enrolled in the subscriber's PEBB medical plan if they lose coverage under another medical plan. Dependents losing other medical coverage must be enrolled within 60 days after termination of the other coverage, and provide proof of continuous coverage to the PEBB program to establish enrollment eligibility.

Eligible employees and dependents may also enroll in PEBB coverage during any PEBB open enrollment period or if the employee acquires a new dependent as a result of marriage, qualified same-sex domestic partnership, birth, adoption, or placement for adoption. Eligible employees and dependents may enroll in these situations without proof of continuous coverage.

An employee/dependent is eligible to enroll in only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans.

## Waiver of Coverage

Employees eligible for PEBB medical coverage have the option of waiving health plan coverage if they are covered by other health plan coverage. To waive coverage, the employee must complete an *Employee Enrollment/Change* form that identifies the individuals for whom coverage is being waived. If an employee waives coverage for him/herself, coverage is automatically waived for all eligible dependents. An employee may choose to enroll only him/herself, and waive coverage for any or all dependents.

An employee may waive only the medical portion of health plan coverage. The employee must remain enrolled in the dental, life, and long-term disability insurance coverages. The appropriate form to waive health plan coverage must be received prior to the date coverage is to be waived.

If PEBB medical coverage is waived, an otherwise eligible person may enroll in a PEBB plan only during the next open enrollment period, or within 60 days of loss of other medical coverage. Proof of other medical coverage is required to demonstrate that: 1) coverage was continuous from the date PEBB coverage was waived; and 2) the period between loss of coverage and application for PEBB coverage is 60 days or less.

The employee and dependents may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, same-sex domestic partnership, birth, adoption, or placement for adoption, provided that enrollment is requested within 60 days after the date of marriage, establishment of a qualified same-sex domestic partnership, birth, adoption, or placement for adoption.

## Enrolling a Dependent Acquired After the Subscriber's Effective Date of Coverage

Subscribers may enroll dependents who become eligible after the subscriber's effective date. Newly eligible dependents must be enrolled within 60 days after the date they become eligible.

1. Newborn or adoptive children must be enrolled within 60 days of eligibility if addition of the child increases the premium. When additional premium is not required, the subscriber should notify his or her

personnel, payroll, or insurance office of the birth, or the placement of the adoptive child, as soon as possible to ensure timely payment of claims.

When a newborn or adoptive child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

2. Dependents who lose other medical coverage must enroll within 60 days after the date their other coverage ends. Dependents will be required to provide proof of continuous medical coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.
3. Eligible dependents may be added during any PEBB open enrollment period without proof of continuous coverage.

Subscribers should contact their personnel, payroll, or insurance office, or PEBB Benefit Services for an *Employee Enrollment/Change* form.

## Disenrolling a Dependent

Employees should contact their payroll, personnel, or insurance office for forms and information on how to update their records. A dependent may be deleted from coverage by submitting an *Employee Enrollment/Change* form to the employee's personnel, payroll, or insurance office.

Please refer to the "Options for Continuing PEBB Benefits" section for more information.

Enrollment changes should be made as soon as possible. Eligibility changes not reported within 60 days after an event that creates a change in premium or loss of eligibility may result in a loss of premiums and a loss of the enrollee's right to continued coverage.

*Failure to notify your payroll office or PEBB of changes in status affecting eligibility may result in termination of coverage. You are responsible for the cost of any services received when you or your dependent(s) were ineligible.*

## When Coverage Begins

Coverage will begin for employees and their dependents as follows:

### For Employees

1. **Permanent Employees, Seasonal Employees, Career Seasonal/Instructional Employees:** Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment.
2. **Nonpermanent Employees:** Coverage for nonpermanent employees begins on the first day of the seventh calendar month following the date of employment.
3. **Part-Time Faculty and Part-Time Academic Employees:** Coverage for part-time faculty and part-time academic employees begins on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, coverage begins at the beginning of the second consecutive quarter/semester.
4. **Appointed and Elected Officials, Judges:** Coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of a month, coverage begins on the first day of their term.

Coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of state government, and judges, on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of a month, coverage begins on the date the term begins, or the oath of office is taken.

5. **Employees of Participating School Districts and Employer Groups:** The effective date of coverage for eligible employees may be determined by the terms of employment or collective bargaining agreement. Participation of the bargaining unit or non-represented employees is subject to approval by the PEBB program.

### For Dependents

Coverage for eligible dependents begins on the day the subscriber's coverage begins if the subscriber lists the dependents on the enrollment form for coverage.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with PEBB rules, coverage begins on the first day of the month following the date of acquisition or declaration. If the date of acquisition or declaration is the first day of a month, coverage will begin on the first day of the month of acquisition or declaration.

Coverage for a newborn child begins at birth. Coverage for an adoptive child begins on the date that the subscriber assumes a legal obligation for total or partial support in anticipation of adoption of the child.

Coverage for other eligible dependents begins on the first of the month following the date the condition of dependency is established and approved by the PEBB program. If the condition of dependency is established and approved as of the first day of a month, coverage will begin on the date dependency is established.

## Special Enrollment for Employees and Their Dependents Who Previously Waived Coverage

Coverage for eligible employees and their dependents whose medical coverage was previously waived will be effective as described below. The employee must enroll to enroll dependents.

1. Coverage for eligible employees and dependents enrolling because of loss of other medical coverage will begin on the first day of the month following the date the prior coverage terminated. The enrollment form must be received by the employee's payroll, personnel, or insurance office within 60 days after termination of other medical coverage, and proof of other continuous comprehensive group medical coverage must be provided.
2. Coverage for eligible employees and dependents enrolling following a marriage or establishment of a qualified same-sex domestic partnership will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage is the first calendar day of the month, coverage will begin on the date of marriage. The application for coverage must be received by the employee's payroll, personnel, or insurance office

within 60 days after the date of marriage or date that the same-sex domestic partnership qualifies based on the declaration.

3. Coverage for eligible employees and dependents enrolling following a birth or placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that the employee assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by the employee's payroll, personnel, or insurance office within 60 days of the birth or date of placement.

## Changing Medical Plans Mid-Year

Enrollees may change medical plans in the following situations:

1. During a PEBB open enrollment period.
2. If an enrollee changes residence during the plan year, he or she may change plan enrollment within 60 days of his or her move under the following conditions: if an enrollee moves from his or her plan's service area, he or she may enroll in any plan available in his or her new locality, or if a plan has not been available to the enrollee and he or she moves into that plan's service area, he or she may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date the enrollee moves.
3. If a court order requires a subscriber to provide medical coverage for an eligible spouse or child, the subscriber may change medical plans and add the dependent immediately, with the change effective retroactive to the effective date of the court order or the subscriber's effective date of coverage, whichever is later.
4. If a subscriber retires for any reason, the subscriber may change plans at the time of application for retiree coverage. The change will become effective on the first day of the month following the retirement date.
5. Seasonal employees whose off-season occurs during open enrollment may change plans within 60 days of returning to work.
6. If an employee's medical plan becomes unavailable, the employee may choose another medical plan within 60 days after notification by the PEBB program. Anyone who does not choose another medical plan within this time period will be enrolled in the medical carrier's successor plan if one is available, or will be enrolled in the Uniform Medical Plan PPO by default. Anyone defaulted to the Uniform Medical Plan PPO may not change medical plans until the next open enrollment.
7. If an enrollee incurs a claim that would meet or exceed the lifetime limit on all benefits.
8. If an enrollee exercises the special enrollment right to add newly acquired dependents due to marriage, a qualified same-sex domestic partnership, birth, adoption, or placement for adoption. The enrollment application must be submitted to the employee's personnel, payroll, or benefits office within 60 days after:
  - The marriage or qualification of same-sex domestic partnership; or
  - Birth, adoption, or placement for adoption of a child.
9. The enrollee's physician stops participation with the enrollee's medical plan and the PEBB appeals manager determines that a continuity of care issue exists. Refer to WAC 182-08-198(2)(f) for specific details.

*When you retire, be sure to enroll in PEBB retiree coverage within 60 days of your retirement date. Retirees may apply to defer medical coverage if they have other employment that provides comprehensive medical coverage. If you do not enroll or formally defer PEBB coverage within 60 days of retirement, you will not be able to return to PEBB coverage later.*

To change plans, subscribers must fill out an *Employee Enrollment/Change* form. Subscribers should contact their payroll, personnel, or insurance office for forms and information on how to update their records.

**Note:** Your contractual relationship is with the health plan you have selected, not the individual providers available through the health plan. If an enrollee's provider or health care facility discontinues participation with UMP Neighborhood, the enrollee may not change health

plans until the next PEBB open enrollment period, except as provided in WAC 182-08-198(2)(f). UMP Neighborhood cannot guarantee that any one physician, hospital, or other provider will be available under the enrollee's care system. Also, if an employee transfers from one agency or school to another during the plan year, the enrollee is not permitted to change health plans, except as outlined above.

## When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.
2. For an employee who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends for the employee and dependents (subject to the dependent's rights to continue coverage) at midnight on the last day of the month in which the employee or dependent is eligible.
3. Premium payments are not prorated if an enrollee dies or terminates coverage prior to the end of the month.

If an enrollee or newborn eligible for benefits under "Obstetric and Newborn Care" is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends, and the enrollee is not immediately covered by other health care coverage, benefits will be extended until:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital and the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted, whichever occurs first.

When coverage ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the timelines explained in the following sections.

As a PEBB enrollee, it is the enrollee's responsibility to pay premiums when due. If the enrollee's account is delinquent, the enrollee's coverage will be terminated at the end of the month for which the last full premium was received. If the enrollee's coverage is terminated due to delinquency, the enrollee's eligibility to participate in the PEBB program will end.

## Options for Continuing PEBB Benefits

Employees and their dependents covered by UMP Neighborhood have options for continuing coverage during temporary or permanent loss of eligibility. There are four continuation of coverage options you may be eligible for as a PEBB enrollee:

- Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- PEBB Extension of Coverage
- Leave Without Pay (LWOP) coverage
- PEBB-sponsored retiree coverage

The first three options above temporarily extend health coverage in a PEBB plan if certain circumstances occur that would otherwise end your or your dependents' eligibility for PEBB medical or dental coverage. COBRA continuation coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

The fourth option above is available only to individuals who meet eligibility criteria for PEBB retiree coverage defined in Washington Administrative Code (WAC) 182-12-171, or surviving dependents who meet eligibility criteria defined in WAC 182-12-250 or 182-12-265.

All four options are administered by the PEBB program. Refer to your *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules* for specific details, or call PEBB Benefit Services at 1-800-200-1004.

Employees also have the right to convert to individual medical coverage when their eligibility for PEBB group coverage ends. Dependents also have this option for continuing coverage. See "Conversion of Coverage" on page 64.

## **Family and Medical Leave Act of 1993**

Employer contributions toward PEBB plan coverage will continue up to the first 12 weeks of approved family leave in accordance with the Family and Medical Leave Act of 1993. Employees must also continue to pay the employee premium contribution during this period to maintain eligibility. After that, coverage may be continued as explained in "Options for Continuing PEBB Benefits" on page 63.

### **Payment of Premium During a Labor Dispute**

Any employee or dependent whose monthly fees hereunder are paid in full or in part by the employer, may pay the fees directly to PEBB if the employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

During the period the employee's compensation is suspended or terminated, the employee shall be notified immediately by PEBB in writing, by mail addressed to the last address of record with PEBB, that the employee may pay the fees as they become due as provided in this section.

## **Conversion of Coverage**

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered by UMP when they are no longer able to continue PEBB group (including COBRA) coverage, and are not entitled to Medicare or other group coverage which provides benefits for hospital or medical care. Enrollees must apply for conversion coverage within 31 days after their PEBB group (including COBRA) coverage ends.

Evidence of insurability is not required to obtain the conversion coverage. The rates, coverage, and eligibility requirements for our conversion plans differ from those of other UMP coverage. Enrollment in a conversion plan may limit your ability to later purchase individual coverage through carriers available in this state without going through health screening and/or a preexisting condition waiting period. To obtain detailed information on conversion plan options offered by UMP, call PEBB Benefit Services at 1-800-200-1004.

# Eligibility and Enrollment for Retirees

## Eligibility

(See “When Coverage Begins” to determine when coverage for eligible enrollees begins.)

## Eligible Retirees

Retired or permanently disabled employees (referred to in this book as “retirees,” “subscribers” or, in some cases, “enrollees”) of state government, higher education, K-12 school districts, educational service districts, and employer groups are eligible for coverage by PEBB plans on a self-pay basis in accordance with Washington Administrative Code (WAC) 182-12-171 and WAC 182-12-211. A retired or permanently disabled employee under WAC 182-12-171 or WAC 182-12-211 is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person. In order to be eligible, the following conditions must be met:

- I. a. Under the following state of Washington retirement systems, individuals must immediately begin receiving a monthly retirement allowance, or have taken a lump-sum payment because their monthly benefit would be less than the minimum amount established by the Department of Retirement Systems:
    - i. Public Employees Retirement System (PERS) 1, 2, or 3 (with the exception noted below in section I.b.i.);
    - ii. Teachers’ Retirement System (TRS) 1, 2, or 3 (with the exception noted below in section I.b.i.);
    - iii. School Employees Retirement System (SERS) 2 or 3 (with the exception noted below in section I.b.i.);
    - iv. Higher Education Retirement Plan (e.g., TIAA-CREF) (with the exception noted below in section I.b.ii.);
    - v. Law Enforcement Officers’ and Fire Fighters’ Retirement System (LEOFF) 1 or 2;
    - vi. State Judges/Judicial Retirement System; or
    - vii. Washington State Patrol Retirement System (WSPRS) 1 or 2.
  - b. Individuals in the following state of Washington retirement systems are not required to begin receiving a monthly retirement allowance, but may instead meet these conditions:
    - i. Public Employees Retirement System (PERS) 3, Teachers’ Retirement System (TRS) 3, and School Employees Retirement System (SERS) 3 not receiving a monthly retirement allowance (defined benefit), must be at least age 55 with at least 10 years of service credit at the time of separation;
    - ii. Higher Education Retirement Plan (e.g., TIAA-CREF), must be at least age 55 with at least 10 years of service, or at least age 62.
  - c. Employees who are approved a disability retirement must apply for coverage within 60 days after the date of the approval notice from the Department of Retirement Systems or their higher-education retirement system.
  - d. Appointed and elected officials of the legislative and executive branches of state government who leave public office may continue their PEBB medical coverage on a self-pay basis whether or not they receive a retirement benefit from a state retirement system, provided they apply no later than 60 days after the end of their term.
2. All eligible retirees must submit an election form to enroll or defer medical coverage **no later than 60 days** after their employer-paid or continuous COBRA coverage ends.
  3. **Retirees and their covered dependents who are entitled to enroll in Medicare must enroll in Medicare Parts A and B.** A copy of their Medicare card must be provided to the PEBB program as proof of enrollment. Enrollees not entitled to either Medicare Part A or B must provide PEBB Benefit Services with a copy of the appropriate documentation from the Social Security Administration.

## Deferring Coverage At or Following Retirement

If the retiree elects not to enroll in PEBB retiree coverage within 60 days after becoming eligible, or the retiree or his or her eligible surviving dependent(s) cancels their PEBB retiree coverage, the enrollee is not eligible for PEBB coverage unless he or she defers PEBB retiree coverage as outlined below.

Beginning January 1, 2001, a retiree may defer enrollment in PEBB medical coverage pursuant to WAC 182-12-205 if the following conditions are met. The retiree must be continually covered under another comprehensive, employer-sponsored medical plan as an employee or as the spouse or qualified same-sex domestic partner of an employee, or as a retiree or as the spouse or same-sex domestic partner on a retiree's retirement coverage from a federal retiree plan.

Pursuant to WAC 182-12-200, a retiree whose spouse is enrolled as an eligible employee in a PEBB or Washington State K-12 school district-sponsored health plan may defer enrollment in PEBB retiree medical plans and enroll in the spouse's PEBB or school district-sponsored health plan. If a retiree defers enrollment in a PEBB retiree medical plan, enrollment must also be deferred for dental coverage.

To defer medical and dental coverage, the retiree must submit a PEBB enrollment form to PEBB Benefit Services indicating his or her desire to defer coverage. This must be accomplished prior to the date coverage is deferred, or within 60 days after the date he or she is eligible to apply for PEBB-sponsored retiree benefits.

## Eligible Dependents

Eligible subscribers may enroll dependents in their PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans. The following dependents are eligible:

1. The retiree's lawful spouse or same-sex domestic partner (qualified through the declaration certificate issued by PEBB).
2. The retiree's dependent children through age 19. The term "children" includes the retiree's biological children, stepchildren, legally adopted children, children for whom the retiree has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, children of the retiree's qualified same-sex domestic partner,

or children specified in a court order or divorce decree. Married children who qualify as dependents of the retiree under the Internal Revenue Code and additional legal dependents approved by the PEBB program are included. Dependent children who are registered students or who are developmentally or physically disabled are eligible beyond the age of 19 under the following conditions:

- a. Students ages 20 through age 23 are eligible if they are registered students at an accredited secondary school, college, university, vocational school, or school of nursing. Dependent student coverage begins the first day of the month in which the quarter or semester for which the dependent is registered begins and ends the last day of the month in which the student stops attending or in which the quarter or semester ends.

To certify and recertify eligibility, the subscriber must submit a *Student Certification/Change* form to PEBB Benefit Services for review, along with proof that the dependent is a registered student. Acceptable proof may include: i) current quarter/semester registration from the institution; or ii) past year report card/transcript from the institution. Misrepresentation or failure to notify PEBB of changes in status resulting in loss of eligibility, including changes in student status, may result in the subscriber being responsible for payment of services received. Coverage of dependent students continues year-round for those who attend three of the four school quarters or two semesters, and for three full calendar months following graduation as long as the retiree is covered at the same time, the dependent has not reached age 24, and the dependent meets all other eligibility requirements.

- b. Dependent children of any age are eligible if they are incapable of self-support and are individuals with disabilities, developmental disabilities, mental illness, or mental retardation, provided that their condition occurred prior to age 20, or during the time they met the criteria for student coverage under PEBB rules. The subscriber must complete an application with proof that such disability occurred either (a) before the dependent became 20 years old; or (b) during the time the dependent met the criteria for student coverage as described above. The subscriber must submit the application to PEBB Benefit Services for approval

by UMP. The PEBB program will, on behalf of UMP Neighborhood, request recertification of disability as frequently as necessary to verify the ongoing eligibility status of the dependent during the first two-year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.

3. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as (a) the parent maintains continuous coverage in a PEBB-sponsored medical plan, (b) the parent continues to qualify under the Internal Revenue Code as a dependent of an eligible retiree, (c) the retiree who claimed the parent as a dependent continues enrollment in a PEBB plan, and (d) the parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible retiree; however, dependent parents may not add additional family members to their coverage.

Verification of the dependency status of anyone enrolled under PEBB coverage may be requested at any time by the PEBB program or UMP Neighborhood.

*Notify PEBB Benefit Services at 1-800-200-1004 as soon as possible of changes in student status. Such changes may result in your being required to pay for services received.*

## Medicare Entitlement

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Office to inquire about Medicare enrollment.

Upon retirement, Medicare will become the primary coverage in most cases, and the PEBB-sponsored medical plan becomes secondary. PEBB plan enrollees retiring July 1, 1991, and after must be enrolled in Medicare Parts A and B, if entitled.

Please contact PEBB Benefits Services for information about retiree eligibility and benefit information.

## Enrollment

Eligible retirees must submit an application to enroll in or defer PEBB coverage within 60 days from the date that their employment or continuous COBRA coverage ends.

Retirees who deferred PEBB medical coverage while enrolled in other comprehensive, employer-sponsored coverage may enroll in this plan within 60 days of the date other employer-sponsored coverage ends or during a PEBB open enrollment period. Proof of continuous enrollment in comprehensive, employer-sponsored coverage is required with the application. Contact PEBB Benefit Services for information on the premiums and coverage available.

Retirees who defer PEBB medical and dental coverage while enrolled as a retiree or dependent in a federal retiree plan will have a one-time opportunity to re-enroll in PEBB medical and dental coverage. To re-enroll in PEBB medical and dental coverage, retirees or their surviving dependents must submit a *Retiree Enrollment/Change* form and proof of continuous enrollment in a federal retiree medical plan to PEBB Benefit Services either (a) during any PEBB open enrollment period; or (b) within 60 days after the date their other coverage ends.

An eligible subscriber may enroll dependents in his or her PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans.

## Enrolling a Dependent Acquired After the Retiree's Effective Date of Coverage

Retirees may enroll dependents who become eligible after the retiree's effective date. Newly eligible dependents must be enrolled within 60 days after the date they become eligible.

1. Newborn or adoptive children must be enrolled within 60 days of eligibility if addition of the child increases the premium. When additional premium is not required, the retiree should notify PEBB Benefit Services of the birth, or the placement of the adoptive child, as soon as possible to ensure timely payment of claims.

When a newborn or adoptive child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full

month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

2. Dependents who lose other medical coverage must enroll within 60 days after the date their other coverage ends. Dependents will be required to provide proof of continuous medical coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.
3. Eligible dependents may be added during any PEBB open enrollment period without proof of continuous coverage.

Contact PEBB Benefit Services for an enrollment/change form.

### Special Enrollment Period for Dependents

Coverage for eligible dependents whose medical coverage was previously waived will be effective as described below.

1. Eligible dependents who were waived **while the retiree maintained enrollment in a PEBB medical plan** may be enrolled during any PEBB open enrollment period, or within 60 days of loss of other medical coverage. Outside of enrollment during a designated open enrollment, proof of other medical coverage is required to demonstrate that: 1) coverage was continuous; and 2) the period between loss of coverage and application for PEBB coverage is 60 days or less. Coverage for eligible dependents enrolling because of loss of other medical coverage will begin on the first day of the month following the date the prior coverage terminated. The enrollment form must be received by PEBB Benefit Services within 60 days after termination of other medical coverage. Coverage for eligible dependents enrolling during a PEBB open enrollment period will begin January 1 of the following year.
2. Retiree's marriage or qualified same-sex domestic partnership: Coverage for eligible dependents enrolling following a marriage or establishment of a qualified same-sex domestic partnership will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage is the first calendar day of the month, coverage will begin on the date of marriage. The application for coverage must be received by

PEBB Benefit Services within 60 days after the date of marriage or date that the same-sex domestic partnership qualifies based on the declaration.

3. Birth or adoption: Coverage for eligible dependents enrolling following a birth or placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that the retiree assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by PEBB Benefit Services within 60 days of the birth or date of placement.

### Disenrolling a Dependent

Retirees should contact PEBB Benefit Services to update their records. A retiree may delete a dependent by submitting an enrollment/change form to PEBB Benefit Services. Failure to notify PEBB of changes in status resulting in loss of eligibility may result in termination of coverage and the subscriber being responsible for payment of services received. Please refer to the "Options for Continuing Benefits" section for more information.

Enrollment changes must be submitted to PEBB Benefit Services within 60 days after the event that created the change.

### When Coverage Begins

Coverage for eligible retirees begins on the day following loss of other coverage provided application for retiree coverage is made in accordance with PEBB rules.

Coverage for eligible dependents begins on the day the retiree's coverage begins if the retiree lists the dependents on the enrollment form for coverage.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with PEBB rules, coverage begins on the first day of the month following the date of acquisition/declaration. If the date of acquisition/declaration is the first day of a month, coverage will begin on the first day of the month of acquisition/declaration.

Coverage for a newborn child begins at birth. Coverage for an adoptive child begins on the date that the retiree assumes a legal obligation for total or partial support in anticipation of adoption of the child.

Coverage for other eligible dependents begins on the first of the month following the date the condition of

dependency is established and approved by the PEBB program. If the condition of dependency is established and approved on the first day of a month, coverage will begin on the date dependency is established.

## Changing Medical Plans Mid-Year

Enrollees may change medical plans in the following situations:

1. During a PEBB open enrollment period.
2. If an enrollee changes residence during the plan year, he or she may change plan enrollment within 60 days of his or her move under the following conditions: if an enrollee moves from his or her plan's service area, he or she may enroll in any plan available in his or her new locality; or if a plan has not been available to the enrollee and he or she moves into that plan's service area, he or she may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date the enrollee moves.
3. If a court order requires a retiree to provide medical coverage for an eligible spouse or child, the retiree may change medical plans and add the dependent immediately, with the change effective retroactive to the effective date of the court order or the retiree's effective date of coverage, whichever is later.
4. If an enrollee is covered under Medicare Part A and becomes enrolled in Medicare Part B, the enrollee may enroll in a Medicare Supplement Plan within six months of enrollment in Medicare Part B.
5. If an enrollee is covered under Medicare Part A and Medicare Part B and elects to enroll in Medicare Part D within the three-month period following the month in which the enrollee turns age 65, PEBB rules require the enrollee to make a plan change and select either Medicare Supplement Plan E or Plan J.
6. If a retiree's medical plan becomes unavailable, the retiree may choose another medical plan within 60 days after notification by the PEBB program. Anyone who does not choose another medical plan within this time period will be enrolled in the medical carrier's successor plan if one is available or will be enrolled in the Uniform Medical Plan PPO by default. Anyone defaulted to UMP PPO may not change medical plans until the next open enrollment.

7. If an enrollee incurs a claim that would meet or exceed a lifetime limit on all benefits.
8. If the enrollee exercises the special enrollment right to add newly acquired dependents due to marriage, qualification of a same-sex domestic partnership, birth, adoption, or placement for adoption. The enrollment application must be submitted to PEBB Benefit Services within 60 days after:
  - The marriage or qualification of same-sex domestic partnership; or
  - Birth, adoption, or placement for adoption of a child.
9. The enrollee's physician stops participation with the enrollee's medical plan and it is determined by the PEBB appeals manager that a continuity of care issue exists. Refer to WAC 182-08-198(2)(f) for specific details.

To change plans, the retiree must fill out a *Retiree Enrollment/Change* form. Retirees should contact PEBB Benefit Services to update their records.

*If you move out of the UMP Neighborhood service area (King, Pierce, and Snohomish counties) during the plan year and choose to enroll in UMP PPO, any amounts paid or services received as a UMP Neighborhood enrollee will not count towards UMP PPO deductibles, benefit limits, or annual out-of-pocket limit. New deductibles, benefit limits, and out-of-pocket limit will apply (see page 5), and your monthly premium will increase as of the date of coverage under UMP PPO.*

**Note:** Your contractual relationship is with the health plan you have selected, not the individual providers available through the health plan. If an enrollee's provider or health care facility discontinues participation with UMP Neighborhood, the enrollee may not change health plans until the next open enrollment period, except as provided in WAC 182-08-198(2)(f). UMP Neighborhood cannot guarantee that any one physician, hospital, or other provider will be available and/or remain offered under the enrollee's care system.

## When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.
2. If the retiree stops paying monthly premiums, coverage ends for the retiree and dependents on the last day of the month for which the last **full premium** was paid. A full month premium is charged for each calendar month of coverage. Premium payments are not prorated if an enrollee dies or terminates prior to the end of a month.
3. For a dependent who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends at the end of the month in which he or she ceases to qualify as a dependent (such as a non-student child reaching age 20, or a spouse when a final decree of divorce is entered).

If an enrollee, or newborn eligible for benefits under "Obstetric and Newborn Care," is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends, and the enrollee is not immediately covered by other health care coverage, benefits will be extended until:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital and the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted, whichever occurs first.

When coverage ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the timelines explained in the following sections.

The enrollee is responsible for timely payment of premiums and reporting of changes in eligibility or address.

As a PEBB plan enrollee, it is the enrollee's responsibility to pay premiums when due. If the enrollee's account is delinquent, the enrollee's coverage will be terminated the end of the month in which the last full premium was received. If the enrollee's coverage is terminated due to delinquency, the enrollee's eligibility to participate in the PEBB program will end.

The enrollee and his or her covered dependent(s) or beneficiary is responsible for reporting changes within 60 days after the event, such as divorce, death, or when no longer a dependent as defined in WAC 182-12-260.

Failure to report changes can result in loss of premiums and loss of your or your dependents' right to continue coverage under the federal COBRA law or PEBB rules. If you need assistance in obtaining the proper form for communicating changes to the PEBB program, please call PEBB Benefit Services at 1-800-200-1004.

## Options for Continuing PEBB Benefits

Some enrollees and their dependents covered by this plan who lose eligibility have options for continuing coverage: (1) PEBB rules allow for continued retiree coverage of dependents of a deceased subscriber, (2) the federal COBRA law gives enrollees the right to continue group coverage for a period of 18 to 36 months. Refer to the *Summary Plan Description of Continuation of Coverage Rights Under COBRA and PEBB Rules* for specific details or call PEBB Benefit Services at 1-800-200-1004.

Retirees and their dependents also have the right of conversion to individual medical coverage when continuation of group medical coverage is no longer possible. The dependents of retirees also have options for continuing coverage for themselves following loss of eligibility.

Retirees and permanently disabled employees of employer groups whose participation in a PEBB plan ends may be eligible to continue PEBB coverage. Refer to the *Summary Plan Description of Continuation of Coverage Rights Under COBRA and PEBB Rules* for specific details or call PEBB Benefit Services at 1-800-200-1004.

## Conversion of Coverage

Enrollees have the right to switch from PEBB group medical coverage (including COBRA) to an individual conversion plan offered by UMP when they are no longer able to continue PEBB group coverage, and are not entitled to Medicare or another group coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage within 31 days after their PEBB group coverage (including COBRA) ends.

Evidence of insurability is not required to obtain the conversion coverage. The rates, coverage, and eligibility requirements of our conversion plans differ from those of other UMP coverage. Enrollment in a conversion plan may limit your ability to later purchase an individual plan without going through health screening and/or a preexisting condition waiting period. To obtain detailed information on conversion options offered by UMP, call PEBB Benefit Services at 1-800-200-1004.

## **UMP Neighborhood As “Creditable Coverage” for Medicare Part D**

Beginning January 1, 2006, Medicare will offer prescription drug coverage for people who have Medicare Parts A and/or B. This new plan is called Medicare Part D. If you have Medicare as your primary insurance, or will soon become eligible for Medicare, you should be aware that you cannot have both Medicare Part D and UMP retiree coverage.

There will be an “open enrollment” for Medicare Part D from November 15, 2005 through May 15, 2006. That means anyone who is currently on Medicare or eligible for Medicare during that time can enroll in Medicare Part D without paying a penalty. Individuals who register

for Medicare Part D after May 15, 2006, will have to show proof that they had “creditable coverage” prior to applying for Part D or they will likely have to pay higher premiums—one percent higher for every month they went without creditable prescription drug coverage.

The Public Employees Benefits Board (PEBB) program has determined that UMP Neighborhood’s prescription drug coverage does qualify as creditable coverage for Medicare Part D. This means that if you decide in future years to drop your UMP Neighborhood coverage and enroll in Medicare Part D, you will not have to pay a premium penalty for Part D.

Creditable coverage is defined by Medicare as being “at least as good” as Medicare Part D coverage. More specifically, creditable plans must pay out in benefits at least much as a Medicare Part D plan would (on average) and provide reasonable access to pharmacies and mail-order prescription drugs.

However, if you drop your UMP Neighborhood coverage and sign up for Medicare Part D, you will need to select a Medicare Supplement Plan offered through PEBB to keep the option of returning to UMP Neighborhood or other PEBB-sponsored health plans in the future. If you do not sign up with a PEBB Medicare Supplement Plan or other PEBB-sponsored coverage, you won’t be able to come back to a PEBB plan in the future.

# Definitions

## Allowed Charge(s)

The maximum amount UMP Neighborhood allows for a specific covered service or supply.

1. **For professional services, durable medical equipment, supplies, and prostheses**, allowed charges are the lesser of the provider's billed charge or:
  - For network providers, the applicable contracted fee schedule amount.
  - For non-network/out-of-network providers in Washington, the UMP fee schedule amount.
  - For non-network/out-of-network providers outside of Washington, a regionally adjusted charge (defined on page 78).

**Note:** The UMP fee schedule identifies certain services and procedures that are reimbursed on a case-specific (by report) basis. The allowed charge for those services or procedures may be based on UMP's fee schedule amounts for comparable services or procedures, billed charges (or percentage of billed charges), Medicare's fee schedules, rates negotiated by case managers, or other method(s) at UMP Neighborhood's discretion.

2. **For network hospitals and other facilities**, allowed charges for services are determined by the provider's contract with UMP. For services from non-network or out-of-network facilities, allowed charges are generally based on the provider's billed charge, unless other arrangements have been made.
3. **For prescription drugs**, allowed charges are based on Express Scripts' standard reimbursement terms for its network pharmacies, unless other contractual arrangements or terms apply.

When medications not normally self-administered are received in a provider's office, the UMP fee schedule amount is based on a percentage of the Average Wholesale Price (AWP) or a percentage of the Average Sales Price (ASP) determined by the Centers for Medicare & Medicaid Services.

UMP Neighborhood reserves the right to determine the amount payable for any service or supply.

## Ambulatory Surgical Center (ASC)

A facility certified by Medicare or accredited by an accreditation organization recognized by the Centers of Medicare & Medicaid Services (such as the Joint Commission on Accreditation of Healthcare Organizations),

that provides services for patients who receive invasive procedures requiring general, spinal, or other major anesthesia. (Examples of invasive procedures are certain biopsies, cardiac and vascular catheterizations, and endoscopies.) The ASC must be licensed by the state(s) in which it operates, unless that state does not require licensure.

## Annual Medical/Surgical Out-of-Pocket Limit

*Please note that only the UMP allowed charge (see definition on this page) is applied to the annual out-of-pocket limit. Charges exceeding the UMP allowed charge are not counted.*

The dollar limit on the amount you are required to pay each year in coinsurance and copayments for medical/surgical services is \$1,500 per individual or \$3,000 per family. Once you have reached this limit, most claims from network and out-of-network providers are paid at 100% of allowed charges, except as otherwise specified in this *Certificate of Coverage*. For additional information see page 5 of this document.

The following services and charges are not counted towards your or your family's annual medical/surgical out-of-pocket limit:

- Annual prescription drug deductible.
- Benefit reductions for failure to comply with medical review/preauthorization requirements.
- Charges beyond benefit maximums, limits, and allowed charges.
- Charges for expenses not covered.
- Copayments for emergency room care.
- Enrollee coinsurance/copayments for retail and our mail-service prescription drugs.
- Enrollee coinsurance/copayments for non-network services (see page 77 for definition of non-network provider).

For more information on how this works, see page 5 under "Your Cost-Sharing Requirements."

**Annual Prescription Drug Deductible**

A dollar amount you must pay each calendar year before UMP Neighborhood pays prescription drug benefits. The first \$100 per individual in allowed charges for prescription drugs (or \$300 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual prescription drug deductible and are your responsibility.

For more information on how this works, see page 5 under "Your Cost-Sharing Requirements."

**Appeal**

See page 50 under "What Is an Appeal?" for an explanation of appeals and how the process works.

**Approved Provider Types  
(or Approved Provider)**

See list on pages 15-16. A category of health care provider approved to deliver services under UMP Neighborhood. Being an "approved" provider type does not indicate the network status of a provider; an approved provider may be a network, out-of-network, or non-network provider. In addition, being an approved provider type does not necessarily mean that you may self-refer to that provider (see "Other Health Care Services" for a list of providers to whom you may self-refer). Some approved provider types, such as massage therapists, must be network providers to be covered by UMP Neighborhood.

**Brand Name Drug**

A particular drug product sold under the proprietary name or trade name selected by the manufacturer.

**Calendar Year**

January 1 through December 31.

**Care System**

Small, customized health care provider networks chosen to participate in UMP Neighborhood. Participating care systems have demonstrated ability to provide cost-effective care and commitment to participate in clinical quality initiatives. UMP Neighborhood enrollees must enroll in a care system through which primary and specialty health care services are provided.

**Chemical Dependency**

An illness characterized by a physiological or psychological dependency on a controlled substance or on alcohol.

**Coinsurance**

The percentage of allowed charges that UMP Neighborhood pays for covered services. See also the definition of enrollee coinsurance (used to refer to the percentage you pay or "enrollee cost-share").

**Coordination of Benefits**

For enrollees covered by more than one health plan, the method used to determine which plan pays first, which pays second, etc., and the amount paid by each plan. Please see examples and description in "If You Have Other Medical Coverage" on pages 53-56.

**Copayment**

A flat dollar amount you pay when receiving specific services, treatments, or supplies, such as an inpatient hospitalization in a care system facility, emergency room care, or a prescription filled through our mail-service pharmacy.

**Custodial Care**

Care primarily to assist in activities of daily living, including institutional care primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervising medications that are ordinarily self-administered. UMP Neighborhood reserves the right to determine which services are custodial care.

**Deductible**

See definition of "Annual Prescription Drug Deductible" on page 73. For an explanation of how this works, see page 5 under "Your Cost-Sharing Requirements."

**Dependent**

A spouse, qualified same-sex domestic partner, child, or other family member of a UMP Neighborhood subscriber (see "Eligible Dependents" on pages 58 and 66).

**Domestic Partner**

A qualified same-sex domestic partner is one who meets the requirements described on the *Declaration of Marriage or Same-Sex Domestic Partnership* form available from PEBB or your agency's personnel, payroll, or insurance office.

## Durable Medical Equipment

Equipment that is:

- Designed for prolonged use;
- For a specific therapeutic purpose in treating your illness or injury;
- Medically necessary;
- Prescribed by the attending approved provider; and
- Primarily and customarily used only for a medical purpose.

## Emergency

See Medical Emergency.

## Enrollee

An employee, retiree, former employee, or dependent enrolled in UMP Neighborhood.

## Enrollee Coinsurance

The percentage you are required to pay on claims for which UMP Neighborhood pays less than 100% of allowed charges.

## Experimental or Investigational

A service or supply is experimental or investigational if any one or more of the following statements applies when the service is provided. The service or supply:

- Cannot be legally marketed in the United States without approval of the Food and Drug Administration (FDA), and that approval has not been granted;
- Is the subject of a current new drug or new device application on file with the FDA;
- Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner intended to evaluate safety, toxicity, or efficacy;
- Is provided under a written protocol or other document that lists an evaluation of safety, toxicity, or efficacy among its objectives;
- Is under continued scientific testing and research concerning safety, toxicity, or efficacy;
- Is provided under informed consent documents that describe the service as experimental or investigational, or in other terms that indicate the service is being evaluated for safety, toxicity, or efficacy; or
- Is unsupported by prevailing opinion among medical experts (as expressed in peer-reviewed literature) as safe, effective, and appropriate for use outside the research setting.

In determining whether a service or supply is experimental or investigational, UMP Neighborhood relies exclusively on the following sources of information:

- The enrollee's medical records.
- Written protocol(s) or other document(s) under which the service is provided.
- Any consent document(s) the enrollee or enrollee's representative has executed, or will be asked to execute, to receive the service.
- Files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service is provided, and other information concerning the authority or actions of the IRB or similar body.
- Up-to-date, published peer-reviewed medical literature (as defined on page 77) regarding the service, as applied to the enrollee's illness or injury.
- Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by the U.S. Food and Drug Administration (FDA), Office of Technology Assessment, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.
- Information that your provider has shown proficiency in the procedure, based on experience and satisfactory outcomes in an acceptable number of cases.
- Expert opinion, at UMP's discretion.

## Explanation of Benefits (EOB)

A detailed account of each claim processed by a medical plan, which is sent to you to describe claim payment or denial.

## Family

All eligible family members (subscriber and dependents) enrolled in a single account.

## Fee Schedule

UMP Neighborhood's maximum payment amounts for specific services or supplies. Network providers have agreed to accept these fees as payment in full for services to UMP Neighborhood enrollees. See "Allowed Charge(s)" on page 72 for more details.

**Formulary**

See Preferred Drug List on page 78.

**Generic Drug**

A drug with the same active ingredient, but not necessarily the same inactive ingredients, as a brand-name drug that is no longer protected by a commercial patent.

**Health Care Authority (HCA)**

The Washington State agency that administers the following health care programs: Basic Health, Community Health Services, Prescription Drug Program, and Public Employees Benefits Board (PEBB). The HCA is also responsible for administering the Uniform Medical Plan Preferred Provider Organization (UMP PPO) and UMP Neighborhood, as medical plan options for PEBB enrollees.

**Home Health Agency**

An agency or organization that provides a program of home health care prescribed by an approved provider type (practicing within the scope of its license as an appropriate provider of home health services) and is Medicare-certified, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or a UMP Neighborhood network provider.

**Hospice**

Pain relief care and support services that address the physical, emotional, social, and economic needs of terminally ill patients and their families without intent to cure. Services may be provided in the home or in a hospice facility, and must be provided through a state-licensed hospice program.

**Hospital**

An institution accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations and licensed by the state where it's located. Any exception to this must be approved by UMP Neighborhood.

The term hospital does not include a convalescent nursing home or institution (or part) that:

- Furnishes primarily domiciliary or custodial care;
- Is operated as a school; or
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

**Maintenance Therapy**

Medical services designed to preserve or retain a current level of activity or health. UMP Neighborhood reserves the right to determine which services constitute maintenance therapy.

**Medical Emergency**

The sudden and acute onset of a symptom or symptoms, including severe pain, that would lead a reasonable, prudent layperson to believe:

- A health condition exists requiring immediate medical attention; and
- Failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of bodily organs, or would place the person's health in serious jeopardy.

UMP Neighborhood reserves the right to determine whether the symptoms indicate a medical emergency.

**Medically Necessary Services, Supplies, or Interventions**

UMP Neighborhood provides coverage for services, supplies, or interventions that are:

- Included as a covered service as described in the "Covered Expenses" section;
- Not excluded; and
- Medically necessary.

Except as provided under "Chemical Dependency Treatment" on page 24, a service is "medically necessary" if it is recommended by your treating provider and UMP's Medical Director or provider designee and if all of the following conditions are met:

1. The purpose of the service, supply, or intervention is to treat a medical condition;
2. It is the appropriate level of service, supply, or intervention considering the potential benefits and harm to the patient;
3. The level of service, supply, or intervention is known to be effective in improving health outcomes; and
4. The level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by

professional standards, then by expert opinion. “Effective” means that the intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

A health intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of “medical necessity,” a health intervention is not considered separately from the medical condition and patient indications for which it is being applied.

An intervention, supply, or level of service may be medically indicated yet not be a covered benefit or meet the standards of this definition of “medical necessity.” UMP Neighborhood may choose to cover interventions, supplies, or services that do not meet this definition of “medical necessity”; however, UMP Neighborhood is not required to do so.

“Treating provider” means a health care provider who has personally evaluated the patient.

“Health outcomes” are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person’s life.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible,

should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet UMP Neighborhood’s definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, in the absence of such standards, convincing expert opinion.

A level of service, supply, or intervention is considered “cost effective” if the benefits and harms relative to costs represent an economically efficient use of resources for the patients with this condition. The application of this criterion to an individual case will be based on the characteristics of the individual patient. Cost-effective does not necessarily mean lowest price.

The fact a physician or other provider prescribes, orders, recommends, or approves a service or supply does not, in itself, make it medically necessary.

Preventive services not covered by the UMP Neighborhood preventive care benefit will still be covered under the medical/surgical benefit if medically necessary.

UMP Neighborhood may require proof that services and supplies, including court-ordered care, are medically necessary. No UMP Neighborhood benefits will be provided if that proof isn’t received or isn’t acceptable—or if UMP Neighborhood determines the service or supply is not medically necessary.

## Medical/Surgical

Term applies to benefits and services that are not related to prescription drug coverage.

## Network Provider(s)

In UMP Neighborhood, network reimbursement level applies to:

- Covered services provided by all providers within your UMP Neighborhood care system;
- Covered services provided by UMP PPO network providers when your care system provider has notified UMP Neighborhood that he or she has referred you for medically necessary care not obtainable within your care system; or
- UMP PPO network provider services for which you can self-refer such as alternative care, women’s

health care, and behavioral health (see “Other Health Care Services” on page 14 for details).

When you use network providers, you receive the highest level of UMP Neighborhood reimbursement and you cannot be billed for the difference between the provider’s billed charges and UMP Neighborhood’s allowed charge (except for services not covered by UMP Neighborhood).

### **Non-Network Provider(s)**

Non-network reimbursement level (60% of allowed charges) applies to:

- Self-referrals to Washington State providers outside your care system other than self-referrals that are described under “Other Health Care Services” on page 14; or
- Any other services from providers outside your care system when UMP is not notified by your care system provider of a referral.

Many non-network providers can bill you for the difference between their billed charge and the allowed charge (see definition on page 72). This does not apply to providers contracted with the UMP PPO network.

### **Nonpreferred Drug**

A prescription drug designated nonpreferred in the *UMP Preferred Drug List* (see page 20) and covered under Tier 3.

### **Normal Benefit**

The dollar amount of the benefit UMP Neighborhood would normally pay if no other health plan had the primary responsibility to pay the claim.

### **Open Enrollment Period**

A period defined by the HCA when you have the opportunity to change to another health plan offered by PEBB for an effective date beginning January 1 of the following year.

### **Out-of-Network Services**

The out-of-network reimbursement level (80% of allowed charges) applies to services from health care providers:

- Who do not have a contract with UMP and to whom you have been referred by your care system provider for covered services not available within the care system, or

- To whom you have self-referred outside your care system because of urgent conditions or medical emergencies.

Most providers paid at the out-of network rate can bill you for the difference between their billed charge and UMP Neighborhood’s allowed charge (see definition on page 72).

### **Out-of-Pocket Limit**

See definition of “Annual Out-of-Pocket Limit” on page 72. For more information on how this works, see page 5 under “Your Cost-Sharing Requirements.”

### **Over-the-Counter Drugs**

Medications that can be obtained without a prescription.

### **Over-the-Counter Equivalent**

An over-the-counter drug or product with identical active ingredients and strength as a prescription drug or product in a comparable dosage form.

### **Partial Hospitalization**

Ambulatory services provided in a hospital setting which permit the patient to return to his or her residence at night.

### **PEBB Plan**

One of several health insurance plans, including the state’s own self-funded preferred provider plans, Uniform Medical Plan Preferred Provider Organization and UMP Neighborhood, offered through the Public Employees Benefits Board (PEBB) program to public employees, former employees, retirees, and their dependents. Benefits and eligibility are designed by the PEBB and administered by the Health Care Authority (HCA) as part of a comprehensive employee/retiree benefits package.

### **Peer-Reviewed Medical Literature**

Scientific studies printed in journals or other publications where original manuscripts are published only after being critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature, for example, does not include information from health-related Web sites or in-house publications of pharmaceutical manufacturers.

### **Plan-Designated Facility**

A facility, such as a hospital, that UMP designates for the performance of a particular service(s) for an enrollee. Some services are covered only if the designated facility is used. Such a designation will be made by UMP Neighborhood Medical Review, Case Manager, or the UMP Medical Director.

**Preauthorization**

Approval by UMP Neighborhood for certain services before they are provided to the enrollee. Preauthorization is not a guarantee of coverage. Failure to preauthorize certain medical services or drugs could result in denial of the claim. Please see “Preauthorizing Services” starting on page 17 for medical/surgical services that require preauthorization, and “Limits on Drug Coverage” on page 22 for information on drugs that require preauthorization.

**Preferred Drug**

A prescription drug that is listed on the *UMP Preferred Drug List* (see page 20) and covered under either Tier 2 (for preferred brand-name prescription drugs) or Tier 1 (for generic drugs).

**Preferred Drug List**

A list of selected prescription medicines that are covered by UMP Neighborhood. Covered drugs on the list are designated by “tiers”: Tier 1 drugs are generic drugs, Tier 2 are preferred brand-name drugs, and Tier 3 drugs are nonpreferred. The *UMP Preferred Drug List* is based on a combination of the Washington Preferred Drug List and the Express Scripts National Formulary.

**Prenatal**

During pregnancy.

**Preventive Services**

Under UMP Neighborhood, only services recommended under the U.S. Preventive Services Task Force guidelines are covered under the “Preventive Care” benefit; see lists on pages 35-39 for specific services covered.

**Primary Care Services**

Medical care from nonspecialist providers including general practitioners, family practitioners, pediatricians, and internists.

**Primary Payer**

The insurance plan required to process the claim first for all expenses allowed under its coverage when an enrollee is covered by more than one group insurance plan.

**Professional Services**

Non-facility medical/surgical services performed by professional providers such as medical doctors, doctors of osteopathy, naturopathic physicians, and advanced registered nurse practitioners.

**Proof of Continuous Coverage**

The Certificate of Creditable Coverage provided to the enrollee by the enrollee’s prior health plan; or a letter from the enrollee’s employer, on the employer’s letterhead, providing the time period the enrollee and/or his or her dependent(s) were covered by health insurance.

**Provider**

An individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

**Regionally Adjusted Charge**

The maximum payment for a specific service or supply allowed under UMP Neighborhood fee schedules, when performed by out-of-network providers and non-network providers outside of Washington State. UMP Neighborhood will establish regionally adjusted charges for each geographic area and service using one of the following:

- Medicare’s allowable charge in the geographic region, which may be increased by a percentage determined by UMP Neighborhood;
- Charges most frequently made by providers with similar professional qualifications for comparable services in the provider’s geographic area (based on the 75th percentile of charge data collected by Ingenix, an organization that maintains the Prevailing Healthcare Charges System);
- Most consistent charge made by an individual provider for a particular service;
- The provider’s actual charge after any discounts or reductions; or
- The UMP Neighborhood or Alternate fee schedule.

UMP Neighborhood reserves the right to determine the amount payable for any service or supply.

**Reimbursement Level**

How much UMP Neighborhood pays for a particular service or provider type (see pages 13-15 under “How UMP Neighborhood Works” for specific details). For example, the care system provider “reimbursement level” is usually 90% of the allowed charge (see page 72).

**Respite Care**

Continuous care for a homebound hospice patient of more than four hours a day to provide family members temporary relief from caring for the patient.

## Secondary Coverage

When you are covered by more than one health plan, you have “secondary coverage” that may pay part or all the rest of the bill from the provider after your primary payer (see page 78) has paid. See “If You Have Other Medical Coverage” on pages 53-56 for details.

## Service Area

The Washington State counties of King, Pierce, and Snohomish. If Medicare is your primary coverage, see “UMP Neighborhood Provisions for Retirees on Medicare” on page 54 for exceptions. See page 15 regarding exception for student dependents attending school outside of this service area.

## Skilled Nursing Facility

An institution, or part of an institution, that provides skilled nursing care 24 hours a day and is classified as a skilled nursing facility by Medicare. Medicaid-eligible, long-term care facilities are not necessarily skilled nursing facilities.

## Standard Reference Compendium

Refers to any of these sources:

- The American Hospital Formulary Service Drug Information.
- The American Medical Association Drug Evaluation.
- The United States Pharmacopoeia Drug Information.
- Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services.

## Subscriber

The individual or family member who is the primary certificate holder and UMP Neighborhood enrollee.

## Substance Abuse Treatment Facility

An institution (or section) specifically engaged in rehabilitation for alcoholism or drug addiction that meets all of these criteria:

- Is licensed by the state;
- Keeps adequate patient records that contain course of treatment, progress, discharge summary, and follow-up programs;
- Provides services, for a fee, to persons receiving alcoholism or drug addiction treatment including room and board as well as 24-hour nursing; and
- Performs the services under full-time supervision of a physician or registered nurse.

## Tier

A term that tells you how much you will have to pay for a covered prescription drug. UMP Neighborhood’s prescription drug benefit categorizes covered medications into three tiers. See page 21 for details on the prescription drug tiers.

## Tobacco Cessation Services

Services provided for the purpose of quitting tobacco use, usually cigarette smoking. Only the *Free & Clear* program is covered by UMP Neighborhood (see page 41 for details). When recommended by *Free & Clear* counselors, nicotine replacements and other drugs prescribed are also covered at no cost to the enrollee. *Free & Clear* is offered at no charge to enrollees, and there is no limit to how many times you may enroll.

## Urgent Condition

A medical condition occurring suddenly and unexpectedly, or exacerbation of an existing condition that requires care and treatment as soon as possible to prevent the condition from becoming an emergency condition. In determining whether an urgent condition exists for the purpose of benefit payment, consideration will be given by UMP Neighborhood to the symptoms of the condition and the actions that would have been taken by a prudent person under such circumstances.